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Ann Tucker, *Assistant Editor*

MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, nurses, public officials and students of social problems find it of special value.

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CAROL L. McCARTY, B.A.
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Trends in outpatient psychiatric clinic resources, 1959

The professional man-hours of service available in outpatient psychiatric clinics throughout the country in 1959 and the trends in these resources over the last five years are presented in this article.

This is one of a series of reports (3, 4, 13, 15, 17) based on the nationwide outpatient psychiatric clinic reporting program established in July of 1954, by the National Institute of Mental Health in cooperation with state mental health authorities (9). This report summarizes data published in the 1959 *Directory of Outpatient Psychiatric Clinics and other Mental Health Resources in the United States and Territories* (14).

In 1959, 1,429 facilities were identified by state mental health authorities as outpatient psychiatric clinics, defined as "outpatient mental health service units with a psychiatrist in attendance at regularly scheduled hours who takes the medical responsibility for all clinic patients" (16). Data on professional staff as of April 30, 1959, were reported for 1,378, or 96 per cent of these facilities, approximately the same proportion as reported in 1954 (1,178 of 1,234 identified clinics) (3). This report includes estimates of trainees of Veterans Administration clinics and some other revisions which were not available for an earlier report on 1959 professional man-hours (17).

Differences in man-hours reported for the two periods may represent factors other than a true change in services available. Staff turnover affects scheduled weekly man-hours reported because the staffing on the reporting day may be a temporary situation (3). Possible errors in reporting, especially for the first reporting period, 1954, may be an additional explanation for some differences.

A total of 265,000 scheduled professional

The authors are all associated with the Outpatient Studies Section, Biometrics Branch, National Institute of Mental Health, U. S. Public Health Service, Bethesda, Md. Miss McCarty and Mrs. Hench are staff assistants; Miss Norman is an analytical statistician; Dr. Bahn is chief of the Section.

TABLE 1

Scheduled professional man-hours per week in outpatient psychiatric clinics and number per 100,000 population, by major professional category, United States, 1959 and 1954

Professional category	Professional man-hours per week					
	Total number		Number per 100,000 population		Percentage distribution	
	1959	1954	1959	1954	1959	1954
Total	265,084	187,589	149	115	100.0	100.0
Psychiatrist	83,142	56,945	47	35	31.4	30.4
Clinical psychologist	67,794	47,467	38	29	25.6	25.3
Psychiatric social worker	96,182	70,788	54	43	36.2	37.7
Other	17,966	12,389	10	8	6.8	6.6

man-hours of service per week for filled positions were reported as of April 30, 1959, as compared with 187,600 as of November 30, 1954 (Table 1). This 41 per cent increase resulted primarily from the establishment of new clinics rather than from the expansion of already existing clinics, a gain that was offset to some extent by an 8.5 per cent growth in the estimated United States population during this period (5, 8). As a result the average number of professional man-hours per 100,000 population rose from 115 to 149, a net gain of only 30 per cent.

VARIATION BY PROFESSION

Man-hours of each of the three major professions comprising the staff of these clinics increased markedly. The gain was somewhat greater for psychiatrists (46 per cent) than for clinical psychologists (43 per cent) or psychiatric social workers (36 per cent); hours of all other professionals increased 45 per cent.

These differences, however, did not substantially change the distribution of professional man-hours by major discipline. Psychiatric social workers continue to contribute the largest proportion of professional man-hours (36 per cent), clinical psychologists, the lowest (26 per cent); psychiatrists provide 31 per cent of the hours. Relatively few clinic man-hours are provided by psychiatric and mental health nurses (one per cent of the total). A variety of other professionals contribute the remaining six per cent of the man-hours; data on these professionals are available upon request.

The distribution of man-hours by full-time and part-time employment and by trainee status within each major professional category also showed little change in the last five years (Table 2).

Although there has been a relatively large increase in part-time employment, full-time employees still contribute two-thirds or more of psychiatric social worker man-hours and of clinical psychologist man-hours. In contrast, both part-time and trainee hours continue to constitute relatively large proportions of the total psychiatrist hours. Trainee hours (51,000) provide nearly one-fifth of all clinic man-hours and one-half of these (25,000) are psychiatrist trainee hours.

In 1954, there were only 33,000 trainee

TABLE 2

Scheduled professional man-hours per week in outpatient psychiatric clinics, by type of employment and by major professional category, United States, 1959 and 1954

Professional category	1959				1954			
	Total number of professional man-hours per week	Percentage distribution by type of employment			Total number of professional man-hours per week	Percentage distribution by type of employment		
		Full-time*	Part-time	Trainee		Full-time*	Part-time	Trainee
Total	265,084	58.7	22.1	19.2	187,589	61.6	20.9	17.5
Psychiatrist	83,142	35.0	34.6	30.3	56,945	57.2	36.7	26.1
Clinical psychologist	67,794	64.1	21.3	14.6	47,467	67.3	16.5	16.2
Psychiatric social worker	96,182	76.9	11.9	11.2	70,788	78.6	9.5	11.9
Other	17,966	50.3	21.9	27.8	12,389	54.3	30.0	15.7

* "Full-time" refers to a work week of 35 hours or more.

hours, of which 15,000 were psychiatrist trainee hours. A large portion of the increase in trainee hours of other professionals is accounted for by hours of medical school students which increased from 600 to 3,400.

An exact count of the number of professional persons working in clinics cannot be determined because the number who work part-time in more than one administratively distinct psychiatric clinic is not known. Nevertheless, based upon the general increase in number of staff reported for each major profession and type of employment, it is likely that the number of professionals in clinics has greatly increased (Table 3).

TABLE 3

Number of professional staff reported in outpatient psychiatric clinics, by type of employment and major professional category, United States, 1959 and 1954

Professional category	1959				1954			
	Number of staff reported by type of employment				Number of staff reported by type of employment			
	Total	Full-time*	Part-time	Trainee	Total	Full-time*	Part-time	Trainee
Total	14,498	4,009	6,902	3,587	9,512	2,958	4,642	1,912
Psychiatrist	6,460	735	4,070	1,655	4,136	533	2,750	853
Clinical psychologist	3,023	1,125	1,334	564	2,053	829	812	412
Psychiatric social worker	3,474	1,915	1,027	532	2,453	1,423	613	417
Other	1,541	234	471	836	870	173	467	230

* "Full-time" refers to a work week of 35 hours or more.

TABLE 4

Scheduled professional man-hours per week in outpatient psychiatric clinics, by geographic region and state, 1959 and 1954

Geographic region and State	1959 professional man-hours per week		1959 man-hours per week per 100,000 population		Percentage distribution of 1959 man-hours by professional category			
	Total number	Per cent change since 1954	Total number	Per cent change since 1954	Psychiatrist	Clinical psychologist	Psychiatric social worker	Other
Total United States*	265,084	+ 41.3	149	+ 29.9	31.4	25.6	36.3	6.8
Northeast	115,298	+ 28.0	264	+ 23.1	31.6	24.0	38.4	6.0
Connecticut	6,452	+ 71.8	268	+ 57.6	40.4	16.6	40.6	2.4
Maine	358	+ 42.1	38	+ 31.0	20.7	55.9	22.3	1.1
Massachusetts	18,248	+ 26.5	372	+ 27.0	40.9	20.9	34.6	3.6
New Hampshire	605	— 3.5	104	— 8.8	37.8	21.5	40.7	—
New Jersey	7,359	+ 30.2	125	+ 16.8	23.3	28.2	47.4	1.1
New York	61,646	+ 14.1	375	+ 10.3	25.9	27.0	40.8	6.3
Pennsylvania	18,678	+ 91.4	165	+ 87.5	41.9	17.8	29.5	10.8
Rhode Island	1,440	+ 16.1	170	+ 11.1	35.4	14.9	40.4	9.3
Vermont	512	+ 49.3	138	+ 51.6	7.0	34.0	59.0	—
North Central	65,093	+ 31.9	126	+ 21.6	29.0	28.3	36.5	6.2
Illinois	19,353	+ 23.3	191	+ 12.4	22.0	32.7	35.5	9.8
Indiana	3,524	+ 40.0	76	+ 28.8	25.0	32.0	42.2	.8
Iowa	2,242	+ 31.4	80	+ 25.0	17.2	26.7	51.9	4.2
Kansas	5,200	+ 36.0	247	+ 29.3	48.5	26.7	24.1	.7
Michigan	8,685	+ 39.5	109	+ 23.9	29.7	28.0	44.9	6.4
Minnesota	3,339	†+ 1.6	98	†— 6.1	23.3	23.1	42.5	11.1
Missouri	4,713	+ 56.8	112	+ 51.4	35.9	27.1	32.9	4.1
Nebraska	1,041	+ 5.7	72	0	34.7	27.8	36.3	1.2
North Dakota	161	+ 80.9	25	+ 78.6	31.1	39.1	28.6	1.2
Ohio	13,475	+ 35.8	139	+ 23.0	38.3	23.4	33.9	4.4
South Dakota	454	+124.8	67	+123.3	19.4	29.7	30.0	20.9
Wisconsin	2,906	+ 54.8	73	+ 43.1	30.2	29.9	35.1	4.8
South	43,271	+ 68.1	81	+ 52.9	30.8	25.1	34.1	10.0
Alabama	1,348	+384.9	43	+377.8	15.0	23.1	52.6	9.3
Arkansas	1,193	+178.1	69	+187.5	12.2	15.1	20.1	52.6
Delaware	604	— 3.2	135	— 19.2	25.2	29.8	43.2	1.8
Dist. of Columbia	4,698	+ 21.3	574	+ 22.9	31.2	22.3	33.3	13.2
Florida	5,617	+ 59.6	120	+ 12.1	18.6	34.4	41.2	5.8
Georgia	1,372	+132.1	36	+111.8	31.5	30.7	37.2	.6
Kentucky	1,082	+ 78.0	35	+ 66.7	30.2	19.2	47.6	3.0
Louisiana	3,404	+ 16.1	108	+ 5.9	50.2	16.1	24.2	9.5

* 1959 data on trainees of Veterans Administration clinics are included in the United States totals only.
† Includes correction of figures presented in a recent publication (17).

TABLE 4—*(Continued)*

Scheduled professional man-hours per week in outpatient psychiatric clinics, by geographic region and state, 1959 and 1954

Geographic region and State	*1959 professional man-hours per week*		*1959 man-hours per week per 100,000 population*		*Percentage distribution of 1959 man-hours by professional category*			
	Total number	Per cent change since 1954	Total number	Per cent change since 1954	Psychiatrist	Clinical psychologist	Psychiatric social worker	Other
Maryland	5,111	+ 74.9	172	+ 50.9	40.5	19.5	26.7	13.3
Mississippi	394	+ 79.9	18	+ 63.6	21.8	37.6	40.6	—
North Carolina	3,554	+129.4	80	+116.2	40.9	24.1	33.3	1.7
Oklahoma	1,214	+101.7	54	+ 92.9	25.2	25.4	25.7	23.7
South Carolina	785	+ 5.1	33	— 3.0	17.6	21.4	61.0	—
Tennessee	2,720	+431.3	78	+420.0	21.5	35.3	36.1	7.1
Texas	4,695	+ 55.1	50	+ 35.1	36.9	24.0	32.5	6.6
Virginia	4,685	+ 74.4	121	+ 53.2	28.5	28.5	29.7	13.3
West Virginia	795	+ 28.8	41	+ 32.3	21.5	22.6	43.0	12.8
West	32,032	+ 50.7	126	+ 32.0	36.7	21.7	33.7	7.8
Arizona	550	+ 60.3	45	+ 21.6	38.2	32.7	29.1	—
California	22,626	+ 50.8	158	+ 30.6	38.4	21.1	33.7	6.8
Colorado	3,598	+ 92.2	218	+ 71.7	47.8	20.1	28.5	3.6
Idaho	100	— 75.1	15	— 75.8	10.0	40.0	50.0	—
Montana	237	— 40.0	35	— 45.3	29.5	54.0	16.5	—
Nevada	326	‡	120	‡	5.5	36.8	36.8	20.9
New Mexico	123	+ 53.8	14	+ 40.0	15.4	10.6	66.7	7.3
Oregon	1,156	+ 30.8	66	+ 22.2	17.6	51.2	40.2	11.0
Utah	739	— 25.9	84	— 35.4	32.5	17.7	33.8	16.0
Washington	2,531	+ 98.5	92	+ 76.9	21.7	19.0	39.2	20.1
Wyoming	46	+ 53.3	15	+ 50.0	43.5	21.7	21.7	13.1
Nonconterminous United States	2,210	+ 90.2	66	+ 67.8	23.9	31.2	42.4	2.4
Alaska	257	+107.9	151	+115.7	35.8	32.1	32.1	—
Hawaii	1,156	+ 56.9	193	+ 29.5	24.1	28.6	42.9	4.4
Puerto Rico	657	+128.1	28	+115.4	19.2	35.5	45.3	—
Virgin Islands	160	+595.7	§	§	25.0	—	—	75.0

‡ No clinics in 1954.

§ 1959 population estimates for the Virgin Islands are not available.

GEOGRAPHIC VARIATION

The growth of clinic service is almost nationwide. Forty-eight states reported an increase in professional man-hours between 1954 and 1959, whereas only five states showed a decline (Table 4). The ratio of clinic man-hours for each 100,000 population, a ratio which continues to vary widely

among the states (from 14 to 574), showed some improvement in all but a few states.

The variation among states reflects several factors: (A) the concentration of clinic resources in industrial areas and in metropolitan centers; (B) the provision of service by metropolitan clinics to residents of surrounding states; (C) the proximity of clinic resources to medical and other professional training centers; for example, almost 50 per cent of the trainee man-hours are in clinics located in five states (California, Illinois, Massachusetts, New York, Pennsylvania) in which are located approximately 2 out of 5 of the professional psychiatric training facilities in the country (1, 2, 10).

The states also differ considerably in the distribution of man-hours by profession. By state, psychiatrist man-hours range from 6 to 50 per cent of total man-hours, clinical psychologist hours from 11 to 56 per cent, and psychiatric social worker hours from 17 to 67 per cent (Table 4). State variation in the interprofessional ratio reflects both local shortages of professional personnel as well as differences in the staffing needs of the diverse types of clinics.

A comparison of clinic growth by geographic region indicates that the South had the greatest relative growth within the last five years. All but 3 of the 17 states in this region showed increases in professional man-hours exceeding 25 per cent; six states showed increases of more than 100 per cent. The South, however, still has the lowest number of man-hours per 100,000 population.

The West ranked second in relative increase during this period. The Northeast had the greatest increase in actual number of man-hours but the least relative change. For both periods, the ratio of man-hours to population in this region (264 per 100,000) was more than twice that of any other region and three times that of the South. In nonconterminous United States, the population ratio for both Alaska (151 man-hours per 100,000) and Hawaii (193 man-hours per 100,000) are above the national average.

The distribution of man-hours by metropolitan and nonmetropolitan area changed only slightly. In 1959, 89 per cent of the man-hours were provided by clinics located in metropolitan areas, where 63 per cent of the population resided (7). In 1954, these figures were 92 and 59 per cent, respectively. The metropolitan-nonmetropolitan differential continues to be somewhat greater for psychiatrist hours than for other professional man-hours; clinics in nonmetropolitan areas provided only 9 per cent of psychiatrist man-hours compared with 13 per cent of clinical psychologist and 11 per cent of psychiatric social worker hours.

Outpatient psychiatric clinics (including those not reporting) were located in 175 (91 per cent) of the 192 standard metropolitan areas in 1959, compared with 152 (88 per cent) of 172 metropolitan areas in 1954 (11).

VARIATION BY TYPE OF CLINIC

There has been a differential growth of clinic resources according to age or other special groups served, full- or part-time clinic schedule, and type of operating agency (Table 5). The number of clinics with services limited to adults doubled in the last five years; more than one-fourth of all clinic man-hours in the country in 1959 were provided by clinics serving adults exclusively. The number of facilities limited to children increased by 10 per cent, the number of clinics without age restrictions or serving both adolescent children and adults by only 5 per cent.

Another significant finding is an actual

TABLE 5

Number of outpatient psychiatric clinics, 1959 and 1954, professional man-hours 1959, by clinic characteristics, United States

Clinic characteristics	*Number of clinics reporting*		*Number of professional man-hours per week*
	1954	1959	1959
Total	1,205	1,578	265,084
Age group served			
Children and adults	632	662	97,867
Children only	381	418	94,707
Adults only	192	298	72,510
*Type of service**			
Full-time	619	911	248,032
Part-time	586	467	17,052
Direct operating agency			
State governmental agency	207	234	32,763
Local governmental agency	106	147	18,335
U. S. Veterans Administration	66	65	28,429
Mental hospital	295	226	15,390
Medical school, general or other hospital	229	285	67,743
College or university	28	25	4,982
Other school	17	21	12,203
Court or correctional agency	23	20	5,361
Other agency	91	145	33,795
Independent clinic	143	210	46,083
Special group served			
Veterans	66	65	28,429
Alcoholics	25	39	4,316
Mental hospital patients in extramural care	90	51	2,342
Court cases	26	24	5,885
College students	10	15	2,903
Mentally retarded persons	5	12	3,106
Other groups	9	19	2,399
No special groups	974	1,153	215,704

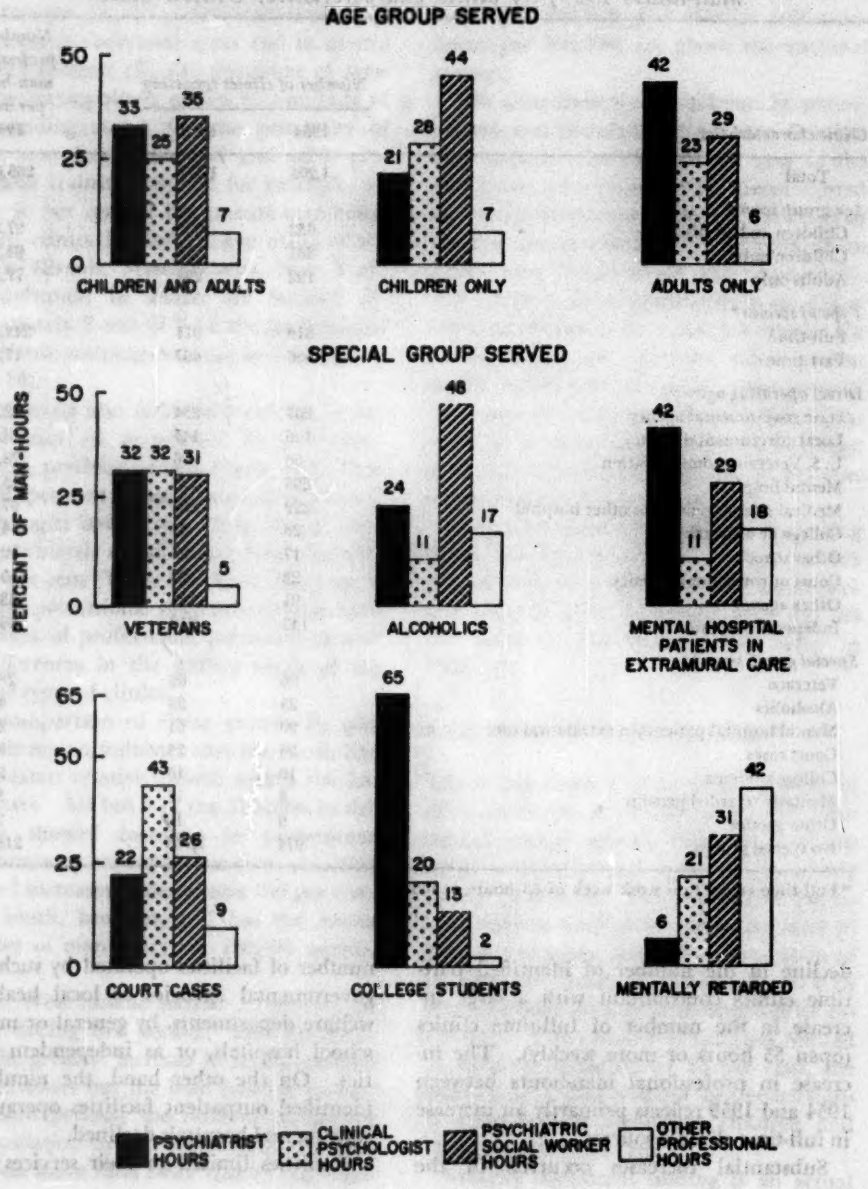
* Full-time refers to a work week of 35 hours or more.

decline in the number of identified part-time clinics concomitant with a large increase in the number of full-time clinics (open 35 hours or more weekly). The increase in professional man-hours between 1954 and 1959 reflects primarily an increase in full-time clinic resources.

Substantial increases occurred in the number of facilities operated by such local governmental agencies as local health or welfare departments, by general or medical school hospitals, or as independent facilities. On the other hand, the number of identified outpatient facilities operated by state mental hospitals declined.

Facilities limited in their services to se-

FIGURE I. PERCENTAGE DISTRIBUTION OF PROFESSIONAL MAN-HOURS IN OUTPATIENT PSYCHIATRIC CLINICS, BY MAJOR PROFESSIONAL CATEGORY, ACCORDING TO GROUP SERVED 1959



lected diagnostic groups or to persons meeting other special eligibility requirements represent about the same part of total clinic resources today as previously.

In 1959, 225 clinics (16 per cent) had special eligibility requirements as compared with 231 clinics (19 per cent) in 1954. The number of psychiatric clinics limited to alcoholics and those limited to the mentally retarded increased substantially (from 25 to 39 and from 5 to 12, respectively); the number serving only the mental hospital patient in extramural care declined (from 90 in 1954 to 51 in 1959).

The specialized services provided by different types of clinics are reflected in their staffing patterns (Figure 1). The ratio of psychiatrist man-hours to other professional staff time is relatively high in clinics serving adults only, college students only, or mental hospital patients in extramural care. Clinical psychologist man-hours predominate in court clinics and psychiatric social worker hours in clinics serving children only or alcoholics only, while speech and remedial therapists and pediatricians contribute a substantial portion of the man-hours of clinics for the mentally retarded.

PROJECTED RESOURCES

A projection of future outpatient psychiatric clinic resources based on the current trend in clinic growth may be helpful in mental health program planning. If it is assumed that in each of the next five years the number of clinic man-hours in the United States will increase at the same rate as in the last five years, clinics will provide 375,000 total man-hours of service per week in 1965 and 529,000 in 1970 as compared with 265,000 in 1959. The 1970 estimated hours would include 177,000 psychiatrist, 138,000 clinical psychologist, 177,000 psychiatric social worker, and 37,000 other professional hours.

Based on these estimates and projected population data (6), the ratio of clinic professional man-hours per 100,000 population can be expected to increase from 149 in 1959 to 191 in 1965 and 248 in 1970. That is, in 1970 there will be an equivalent of 1.8 full-time clinics (defined as 140 man-hours of service per week) for each 100,000 population in the United States. Similar projections by geographic region provide an estimate for the Northeast of 2 clinics per 100,000 by 1965.

By 1970, it still will be the only region having attained this modest goal. The West and North Central regions will have reached the level of 1 clinic per 100,000 population by 1965, while the South will reach this level by 1970. However, it is possible that the man-hour growth rate in the South will be accelerated since almost half of the psychiatric training facilities established in the last few years are located in this region.

SUMMARY AND DISCUSSION

During the five-year period 1954 to 1959, the number of professional man-hours in outpatient psychiatric clinics in the United States increased by 41 per cent, largely because of the establishment of new facilities. The average ratio of man-hours per 100,000 population in 1959 was 149, the equivalent of slightly more than one full-time clinic (defined as 140 man-hours of service per week). The rate of increase was marked for all three major professional categories: psychiatry, clinical psychology, and psychiatric social work.

In general, the greatest clinic growth occurred in the South, the area with the least resources in conterminous United States. Despite this increase, clinic resources in this region average only slightly more than half a full-time clinic per 100,000 population. The Northeast, with 264 man-hours

per 100,000 population, continues to have twice the ratio of any other region and three times that of the South.

Unless the current clinic growth rate is greatly accelerated to offset the anticipated population growth, there will be an average of less than the recommended objective (12) of one clinic per 50,000 population in the United States in 1970.

For adequate program planning of mental health resources, additional types of information are needed on a periodic or special study basis. It was assumed that personnel, as of the day reported, represent the normal staffing of the clinic; however, staff fluctuations because of seasonal or other factors are not known.

A detailed report of professionals who work in the clinic during the year and their dates of employment could provide information on staff turnover as well as unduplicated counts of individuals working in mental health facilities. This report should include such descriptive information about the staff as demographic characteristics, educational and experiential qualifications, and salary.

The functions of the individual staff members in relation to their characteristics and to the clinic policies, goals, and treatment setting also require study. Such additional data on the clinic's training activities as type and amount of trainee supervision and the trainee's role in the clinic, the clinic's inservice training needs and demand for additional staff, will aid in the long-range development of an adequate mental health manpower supply.

Professional organizations and the state mental health authorities are being surveyed to ascertain their requirements for additional types of information related to mental health clinic resources.

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MATHEW ROSS, M.D.

Mental health programs in the decade ahead

If an historian 100 years from now had no source materials to work with other than the slogans of our time, he could reconstruct a fairly accurate history of psychiatry in the period of 1948–1960. He might write the following:

"In summary then, we may say that psychiatry, shortly after World War II, determined to launch a frontal attack on the shameful conditions prevailing in mental hospitals. It resolved to storm the walls of these institutions and make of them active treatment centers. Substantial headway was made in raising their standards. However, only a few years passed before the profession began to have doubts about the long-range potential of its large public hospitals (apparently they were enormous) for becoming the effective treatment centers they had hoped.

"They began to retreat from their bold position and talked a great deal instead about treating mentally ill persons in the community. This represented a very drastic departure for, as we have seen in preceding chapters, the United States had relied almost exclusively on its mental hospitals for the treatment of mental patients for nearly 200 years. From what fragmentary evidence is available, it appears that in some respects the retreat was a disorderly one. At least the spokesmen of the times had not clearly delineated in their own minds exactly what would be the relative roles of the traditional hospital on the one hand and community services on the other.

"There was some talk of abolishing mental hospitals, but apparently this did not materialize. As we shall see in later chapters, the mental hospital continued to play a vitally important role in succeeding years. Nevertheless, the seeds of a new approach to mental illness in the community were sown in the 1950's, and many of them sprouted and flowered in the 1960's."

Dr. Ross is medical director of the American Psychiatric Association, Washington, D. C. This paper was adapted from an address presented to the Northeast State Governments Conference in Stowe, Vt. in May, 1960, and from an address presented to the Mental Health Council of the Western Interstate Commission for Higher Education in Harrison Hot Springs, British Columbia, Can., in June, 1960.

Every man must be his own historian, of course, but it seems to me that we are forming ranks for the long march into the 1960's under a new banner of community-based psychiatry. We feel that we have overcome in some substantial measure "the shame of the states" that gave us our rallying cry in the late forties and early fifties. This is no mean accomplishment. But now we want to go on to constructing positive programs of which we can be proud.

All of us are participating in this vast movement to disperse responsibility for the treatment and care of the mentally ill among broad segments of the community, away from *exclusive* reliance on the large public mental hospital of the past. As to the forms of the movement, we are all well-acquainted with them: the day hospital, the night hospital, the psychiatrically oriented general practitioner, the general hospital psychiatric service, halfway houses, various types of outpatient clinics, mental health centers, rehabilitation centers and all such devices that we consider comprise an integrated network of community psychiatric facilities. Wherever the mental health disciplines congregate, the talk and the slogans focus on the word "community."

> "Times do change. Ideas do have impact on our times. The challenge ahead is stimulating. The prospects for advance in the field of mental health magnificently promising; the battle difficult but not insuperable—and well worth the cost."[1]

I have been asked to convey to you some of my thoughts about mental health programs in the 1960's. It is a good subject. Probably all of us feel an urgent need to redefine our assumptions, goals and methodology as we gird ourselves for the battles of mental illness and health in the decade we have just entered. By the same token, perhaps, we all sense the obsolescence of the assumptions, goals and methodology with which we fought the good fight in the fifties. They simply will not do any longer. A major task confronting us is to find out why this is so, whither we are tending, and how to get there most expeditiously.

ECONOMICS AND MENTAL ILLNESS

At the outset we must systematically examine our present and prospective needs and resources, then, as has been done successfully by highway officials and educators, and present to the nation a well-thought-out target for the next decade. We the people, that is, must assume a correlative responsibility to support the taxes required to achieve that target, and only when we have manifested a willingness to do so can we lay claim to maturity and responsibility.

One may hope, for example, that with the help of economists we can convey to our citizens in the sixties a more realistic appraisal of the true cost of mental illness in terms of undermining our strength as a nation. If we can do this, then presumably citizens will respond with the financial support we need to multiply our efforts a thousandfold to combat it. At least, we must proceed on that assumption.

Certainly we need the help of economists to assess our position realistically, for it has always seemed to me that we in the mental health disciplines have a tendency to think that we are going to save the public money if only it will adopt this or that recommendation or ours. We may say, for example, that since it costs $30 million

[1] From an address delivered by Sidney Spector at the 10th Mental Hospital Institute of the American Psychiatric Association in Kansas City, Mo., October, 1958.

to build a new 3,000-bed hospital, if they will only let us have that $30 million to develop community services, why then it won't be necessary to build any new hospital. *Ergo:* the implication is that the taxpayer is going to save money and we're jolly good fellows for telling him how.

Well, I for one doubt very much if we are going to save anybody any money, or even if that is our function. On the contrary, if we have our way I very much suspect that we are going to double public expenditures on mental illness—and for all I know triple it—in the decade ahead. At least I am sure that we must do something of that order if we are to advance levels of treatment, training and research in our field to the levels that we appear to want. The economists can evaluate its feasibility.

Indeed, Economist Rashi Fein [2] is most persuasive when he says that not even an economist can answer the question: What can society afford to spend on mental illness? But when one raises the question "What *should* society spend on mental illness?" his answer is: "An economy can afford to spend what it desires to spend. All that is necessary in order to spend more on one thing is to spend less on something else. What society can spend (and ultimately what society should spend) depends on the value system that society holds to."

For me the problem is one of communication and motivation—how to release the generous impulses of the people, how to convince them that spending more money on mental illness than on potted plants is a wise thing to do and is in their best interests. My faith in our democratic system makes me feel confident that it can be done, if only we can define the target in such a way that they will want to shoot at it with us.

STANDARDS

In the past 10 years we have been primarily concerned with quantitative factors underlying treatment and care in the hospitals. That is, we sought to eliminate overcrowding in the hospitals, to build up ratios of personnel to patients, to raise salaries, to establish minimum per diem rates. Now it appears that in the decade ahead we are going to be more concerned with *qualitative* factors. If we are to change present concepts into reality, we must, more than anything else, build in self-criticism and question ourselves as we move toward changing present concepts into living reality.

Standards are, of course, a stock device used by professional groups to insure and advance adequate levels of performance in the discharge of services that affect the public as a whole. As they develop in response to a social need, standards can also constitute a rallying point, a set of slogans, if you will, behind which public support can be rallied to advance a cause. The standards of bygone days had to be geared to the most elementary realities, for all aspects of mental hospital care were hopelessly inadequate.

Moreover the early standards—*and we are still using them*—had necessarily to reflect the current philosophy of treatment of the time. While there was some talk in the late forties about community relations and outpatient clinics, it really did not amount to much, for it was not a time for idealism, for projections of what truly civilized treatment of mental illness might be like, but it was a time to erase snakepits. If the mental health disciplines recognized that a majority of patients would respond promptly to an intensive treatment pro-

[2] Fein, Rashi, *Economics of Mental Illness* (New York: Basic Books, Inc., 1958).

gram, they also recognized that for large numbers of patients there was less expectance of recovery, and that for this latter group prolonged treatment would be necessary. We distinguished between intensive treatment for some and what was so euphemistically called "continued treatment" for others.

Largely as a result of the efforts of the APA Central Inspection Board to inspect and rate the mental hospitals of America, minimally acceptable levels of humane care have been achieved and considerable headway has been made in providing treatment programs in our hospitals. Yet hardly were the standards pronounced, when a whole slew of developments took on substance during the fifties which led to the realization that the standards had their own obsolescence built into them. We must understand the nature of this obsolescence, because we are entering the new era of the sixties with a set of standards designed to meet the needs of the late forties and fifties. Certain patterns of dissatisfaction with the standards have been delineated.

The most common note of criticism is that the standards emphasize quantitative considerations at the expense of quality. Furthermore, they proceed from the assumption that more personnel per se will lead to more effective treatment. The qualities of personnel are overlooked. For example, hypothetically, might not a hospital that fails to meet the standard ratio of physicians-to-patients but whose physicians are all Board-certified be a better hospital than one which does meet the ratio but with less adequately trained personnel? Is it sufficient to insist on so many square feet of space per patient, or is there not need to assess how the space is being used and to look more deeply into matters of design and utility? Is it not the results that are obtained rather than the numbers of personnel that count?

Another common dissatisfaction is that the standards no longer reflect our philosophy of treatment. Of course, although one should recognize that there are very large numbers of patients for whom we can still do relatively little, our sights have been raised enormously as to how many patients we can reach if present available therapies are made available within and outside the hospital. And even in the case of chronic patients we are optimistic about making more useful citizens of them within the hospital and in protected settings outside. In short, we are rapidly approaching, if we have not already reached, a philosophy of total treatment for all instead of intensive treatment for some. The former philosophy tended to emphasize arithmetic deficiencies in operations, while the latter tends to confer credit on experimentation, improvisation and built-in evaluation.

A third criticism is that once standards are established it is difficult to change them, because they tend to petrify while they lose touch with the realities of changing opinion and practice. For example, the standards were promulgated before the advent of drug therapies, which have drastically affected the use of space and personnel in the mental hospitals. Still, no change has been made in the standard to reflect this. It is a matter of record that there are not enough nurses in the entire nation to staff the mental hospitals in the ratio required by the standards.

Only rarely will a hospital have more than one-tenth or one-twentieth of the number required. The deficiency, of course, is compensated for by building up staffs of aides and attendants. Is it not time that the standards came to grips with such a fundamental reality?

Another flaw in the standards, often ex-

pressed, is that they do not allow for evaluating the variables in the total effectiveness of individual hospitals. Why is it that some hospitals demonstrate greater therapeutic effectiveness than others? Is it because of superior personnel? Superior administrative techniques? Cultural differences in the patient population? The openness of the hospital? The activity programs? Or why?

The standards do not help us to ascertain the relative importance of these factors. Moreover, they do not have across-the-board applicability to begin with. Certainly the measurement of performance of a large metropolitan hospital in New York is a vastly different proposition from assessing the effectiveness of a hospital in Idaho.

Another troublesome point about standards is that people do attain them. When that point is reached, their very existence becomes a handicap to further advance. Yet, it is not feasible to go on raising the standards every few years to accommodate the needs of those who have reached them. That would amount to nothing more than the old trick of dangling a carrot on a stick in front of the horse. It may work with a horse, but it will not work with a legislator.

So much for some of the patterns of dissatisfaction that are commonly heard these days. It all adds up to a consensus that the standards that did so much for us in the fifties have now almost reached the point where they inhibit rather than encourage the development and application of new and promising trends and practices. Such basic questions arise as whether standards should any longer be geared to accreditation purposes, or whether instead we should think in terms of developing guide lines to acceptable patterns of operation for the entire range of psychiatric services in both the hospital *and* community.

Let me hasten to say that no one, I think, has any notion of dismissing present standards until a more satisfactory formulation is ready to substitute for them. Even now the majority of our mental hospitals have not met the standards which still comprise our best argument for pleading for more appropriations in order that they may be met.

Nevertheless, in terms of setting up the target that we want the public to shoot for in the sixties, I suggest to you that the personnel ratios and the space ratios that were our guideposts in the fifties will simply not see us through the sixties. We must do better. In a word, we must become more concerned with quality, performance and service rendered than with mathematical ratios, without, of course, denying the significance of the latter.

THE PERSONNEL PROBLEM

If we must do some radical thinking about the standards and slogans that we shall march under into the sixties, we must also do some radical thinking about the personnel problem, for the specter of continuing shortages is very much with us. The scope of the problem has been most comprehensively delineated for us by Dr. George Albee.[3]

I suppose that in the sixties we as a nation will develop a few more medical schools, some more graduate schools of psychology, social work, and nursing. But is anyone so sanguine as to believe that we will be able to establish enough schools and acquire enough teachers to overcome our shortages in relation to population growth

[3] Albee, George W., *Mental Health Manpower Trends* (New York: Basic Books, Inc., 1959), Monograph Series #3.

in the sixties? I do not think so. We can, we must, and we will make some progress, but not enough. We will probably make greater progress by way of improving administrative techniques, by making better use of the time and skills of the wide range of professional and nonprofessional personnel that are available to us, by retaining what personnel we do have, by providing more job satisfactions for them and thus stimulating greater productivity among them and by doing a better job or training psychiatric personnel to meet the changing needs of the sixties.

For example, what use are we now making of trained information specialists in our field? Is it too farfetched an idea that the cause of the mentally ill would be well-served if we could set up a national school for training such specialists in communicating our needs to the public? We have by no means given this group of helpers their rightful place on the team, although gradually it is beginning to dawn on most state departments of mental health that they cannot compete for the support they need without the help of experts in communication.

I have been gratified to observe that several states now do have information specialists on their staffs as part of the team, and that these are showing some signs of wanting to organize themselves informally. This is all to the good, and one would very much hope that before this decade is over every department of mental health and some of the hospitals will have adequate information specialists on their staffs as part of the professional team. It is not a matter of building up a vast propaganda machine. It is merely an acknowledgement that we in the mental health disciplines are simply not trained to communicate our needs to the public on which we depend. We owe it to the public to be able to tell them what we are doing and what we want to do in a way that they can understand. We must have help in doing so. And again, it seems self-evident that in the long run our success in communicating will have an important bearing on dealing with the personnel shortage problem.

It is so easy to despair when we look at our prospects in the national picture as a whole. When one sees the striking imbalance between private and public expenditure, it appears that our economy is almost immutably chained to this imbalance, although I had best leave it to the economists to spell it out. We can even go down to our nearest supermarket these days and buy a power mower, an electric blanket, a hi-fi record, or what will you. But just try to get garbage collection improved, prod an official to do something about pruning rotten limbs on the trees that line our city streets, enlarge recreation facilities for the children, reduce overcrowded classrooms, or get more personnel to provide decent treatment and care for the mentally ill, to cite another low priority.

It is this situation that made it possible for Dr. Jack Ewalt to point out to the Congress that the $100 million he asked for the National Institute of Mental Health last year was only one-sixth of the amount we spent on flower seeds and potted plants in 1957. It is, I repeat, easy to become discouraged.

Another constructive approach has to do with getting our salaries raised. Actually we have done fairly well in the past decade in securing better compensation for our staff people, especially salaries for physicians. While we have not done as well by the other categories of personnel, some headway has been made. We must do better in the sixties if we are to hold on

to the personnel we now have, let alone acquire some more. The present wide disparity between the salaries of physicians and the other professions must be reduced in some equitable way. Don't misunderstand me. I am simply saying that the other professions are making less than they are entitled to, and it behooves all of us in general, and physicians in particular, to take the lead in remedying the deficiency.

Again, however, it is easy to despair. Does anyone seriously think that raising the salary of psychologists, nurses, aides, or anyone else by say $500 a year, $1,000 a year, or even $2,000 a year, is going to solve our problem? I doubt it. *It will help. It is terribly important.* But I think it will not solve our basic problem. We can only hope that before long our nationwide concern about the problem will crystallize in the form of a most exhaustive study and an analysis of all aspects of the problem leading to an action program that will produce some concrete results for us before the end of the sixties.

One thing—over which we have immediate control and which involves in essence nothing more than good leadership in our state departments of mental health and in our hospitals and other facilities—is to develop in all of these installations an atmosphere that is intellectually stimulating to the staff right across the board through all the various categories of personnel.

Results of interviews held with psychiatrists, nurses, teachers, residents and other physicians working in various kinds of public and private settings indicate—when the interviewees were asked to rate eight factors (intellectual stimulation, pay, prestige and status, regular work hours, security, freedom, respect of patients, type of patient worked with) determining their satisfaction with their jobs according to their importance and according to the degree that each factor was present where they worked—that "intellectual stimulation" seemed by far the most crucial basis for work satisfaction. Most of the interviewees rated it as being in less supply in their present jobs than the other satisfactions mentioned. When an interviewee indicated the supply of intellectual stimulation was about equal to his assessment of its importance as a factor, then work satisfaction was high. When the difference was great, it was low.

While the authors[4] make no pretension of definitiveness with regard to the study, it does suggest that we may be overlooking one productive approach to the personnel problem that is within our grasp and which need not involve great sums of money. We must liven up the intellectual climate of our offices and our wards. The means of doing this are far more costly of imagination and leadership than of money.

The ingredients of an intellectually stimulating atmosphere are, of course, varied and subtle. I cannot tell you how to do it.

Just to throw out a few suggestions: I am constantly reminded that many of our physicians are foreign-trained and have great difficulty in communicating with our patients because of language difficulties. If this is so, why isn't more effort made to teach them English? What's wrong with getting university extension departments to offer courses to staff personnel? Are there not many aides who would be interested in earning the high school certificate that they passed up a few years

[4] Rettig, Solomon, Frank N. Jacobsen and Benjamin Pasamanick, "The Motivational Patterns of the Mental Health Profession," *Psychiatric Research Reports, #10* (Washington, D. C.: American Psychiatric Association).

back? Is there not a group of miscellaneous people in the hospital—an engineer here, a social worker there, perhaps even a housekeeper—who just might be interested in a Great Books course, instruction in carpentry, or gardening, or Freudian theory? It does not greatly matter, I suggest, what the subject matter is so long as there is interest in it and so long as learning is going on.

And what about meetings, and the problem and expense of getting people to them? Obviously only a very small percentage of mental hospital personnel is ever going to travel to an annual meeting of the American Psychiatric Association or the annual APA Mental Hospital Institute. It is too costly. But why isn't there more imagination about holding smaller regional meetings to which people can travel in groups in their own cars without significant expense?

Why not charter a plane on a Dutch-treat basis to fly a group of staff people over to England to visit the British open hospitals, for example? Make seats on the plane available on a first come first served basis, regardless of professional status.

Has anybody ever thought of giving a staff member three months of leave with pay after he has sweated it out faithfully for 10 years? Is there anyone who can avoid becoming squeaky in the joints after 10 years of routine? Are university people the only ones who can benefit from a sabbatical? Think of what it would mean to have a few months in which one could perhaps go back to school, take an extended trip, putter around the house, lie on the beach, or what you will. Would one not return to his job with enormously greater zest to face another decade of hard work?

Now and then an opportunity comes along to confer some new and exciting challenge and responsibility on personnel, a responsibility that requires new learning, new habits, new psychological sets. A good example, I think, is the Remotivation Therapy Project which the American Psychiatric Association has sponsored in many hospitals throughout the country. I have been given to understand that on the whole the project has been well-received where it has been tried, and that it has been considered of some benefit to the patients.

But I wonder if it has not been even more important as a morale builder for the aides who have been called upon to be the leaders in this endeavor. Have they not been stimulated to levels of performance that were not before expected of them? I am not sure, but I hope so. It seems to me that we must constantly search for new things for people to do, new skills for them to learn. In our status conscious culture there is altogether too much thought given to what others must not do. And, incidentally, while there is not space enough to dwell on it here, I should hope that by the end of another 10 years our psychiatric aide shall truly have arrived not as a new profession but as a highly respected, well-paid technical specialty equal in prestige and income at least to that of a highly skilled tradesman.

One cannot help wonder about the effect of our administrative attitudes which all too often prohibit our realizing the full potentials of our colleague-employees. We must *assume* unlimited capacity for learning, for performance, for improvement among all the people who work with us. If we *assume* it, and if we *feel* it, then we will *act* it. And if we are disappointed at the results in some cases, we shall be truly astonished at the productiveness that results in others. Many a wallflower will burst miraculously into bloom under this

kind of leadership. We will do well to tear down at least a part of the iron curtains fabricated of university degrees and civil service regulations that so inhibit us from truly working together on the common task.

PSYCHIATRIC EDUCATION

Certainly the burgeoning of community psychiatry and the changing role of the psychiatrist in this ferment augurs important changes in the content and methodology of graduate training in psychiatry in the sixties. It is encouraging that our leaders are planning a major conference on the problem—patterned after the APA Cornell Conferences on Psychiatric Education held in the early fifties—which will be designed to evaluate the relative adequacy of all aspects of the training of a psychiatrist insofar as it does or does not prepare him to discharge his responsibilities: as a physician in the medical community; as a psychiatrist in public services; as a research investigator; as a teacher; as a specialist consultant on psychiatric aspects of social problems.

Because the Community Psychiatrist Model of 1960 has become quite a different fellow from the 1950 Model, new molds must be cast to turn out the latest model in quantity. Considerable effort must be spent in finding out just what roles psychiatrists are being asked to play in the community and how to modify curricula to prepare for them, for at the moment the picture of the modern community psychiatrist is a hazy one.

Recently the APA-NAMH Joint Information Service analyzed biographical data of 874 members of APA as of 1957.[8] Two-thirds of these said that they treated private patients, but of these only 13.5 per cent said they were engaged solely in private practice. Over half of all of them had some hospital affiliation, but only 16 per cent said this was all they did. One-third had academic appointments, but less than 1 per cent said it was their only activity. Significantly, one-fourth were associated with outpatient clinics or social agencies but only 3 per cent of them exclusively so. All in all, 60 per cent of the sampling indicated more than one major professional activity, 35 per cent, two activities, and about 25 per cent, three or more major activities.

Clearly, while the psychiatrist, like other physicians, spends a good deal of his time in hospital and clinic work and in private practice, it is his role as a specialist "consultant" on a broad range of social problems that sets him off from the conventional medical pattern. A hint about this appears in a revealing study of exactly what graduates of one major psychiatric institute did after completing their training. Two-thirds entered private practice, 20 per cent did full-time teaching and/or research. Significantly, however, *more than half of those in private practice were spending 1–5 hours a week in community mental health work.*

The investigators found it possible to list 19 different types of community mental health activities: consultative work with school systems, probation departments, courts, family service agencies, public welfare departments, residential homes for children and aged, prison systems, public health departments, rehabilitation agencies and private industry, teaching, outpatient clinics of various kinds, college

[8] "Number, Distribution and Activities of Psychiatrists," *Fact Sheet Number 10* (Washington, D. C.: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, August, 1959).

health programs, general physicians, nonpsychiatric hospitals, and nonmedical therapists.

Interestingly, 53.8 per cent said they were members of a local mental health association and nearly half of these held some office or served on some committee in the society. An astonishing 75 per cent of them said that they participated in such various kinds of public education activities as addressing lay audiences and appearing on TV and radio programs.

Thirty-eight per cent of those who trained at the institute between 1948 and 1953 thought their preparation for community service had been unsatisfactory, but of those who had trained between 1953–58, only 18.5 per cent thought so. One-third of the group felt that the best preparation for community work was to provide some supervised field experience in doing consultation with agencies and individuals within the community.

In general the survey revealed that a large proportion of psychiatric residents need preparation for community mental health work, and it may be hoped that our training centers will devote more concentrated attention to the problem in the years ahead.

It is, I suspect, probably true that the modern community psychiatrist is at the moment more a product of the social pressures that have been thrust upon him fortuitously than he is a product of our present training curricula. The fortuitous proliferation of community psychiatry does contain within it the risk that the psychiatrist may lose his integrity and identity as a physician. If, however, the community psychiatrist of the future is given thorough preparation for that role in medical school and graduate training, the danger will be substantially reduced.

These are but a sampling of the exciting vistas and challenges in the decade ahead.

BETTY V. BLASS, B.S.

One step at a time

"It's hopeless; people just won't accept you after years of this," predicted my friend, as she waited with me for my release.

"This" was a mental hospital. I was going home at last.

"Oh, don't be too sure of that," I answered. "People aren't *all* against us. You'll see."

And it was true. I know it because I am making a fairly successful readjustment after being lost in the nightmare world of schizophrenia. It is a long, never-ending fight against the monstrous superhuman beings that plague me from time to time. But I am one of the lucky ones who wasn't left forever to vegetate in some back ward of the state mental hospital.

I was rescued, and I am trying to help myself, now. Many times it just doesn't seem worthwhile. But the point is, I am making it. And perhaps by telling my own story I can help others to understand the enormous difficulties of communication with the so-called "real" or "outside" world. Of course what worked for me might not work for another person with the same trouble, since everyone is different. But few recovered or recovering schizophrenics clearly remember the stages of this process. I *do* remember and I'd like to tell others how it is being accomplished.

Today schizophrenia is no longer considered hopeless. Some recover, some improve to varying degrees, and some don't. At least now no physician turns up his hands in futility at an early case of it anymore than he would an early case of cancer.

The important thing is to recognize the symptoms and not be afraid to seek psychiatric treatment early. These symptoms are numerous, but everyone should recognize a

Miss Blass is employed in the rehabilitation department of the University of Wisconsin Hospital in Madison.

All of the names in this paper, with the exception of Miss Blass', are fictitious.

few simple ones: loss of interest in other people and affairs, exaggerated daydreaming, violent reactions to common frustrations, extreme silliness of conduct and a curious sense of unreality. Any of these symptoms may be the indication of such an illness developing, and recognition of them is not something to be ashamed of. It is only common sense to seek treatment just as promptly as if it were cancer or a broken leg.

Mental hospitals have lost their former unsavory stigma. Improved conditions have occurred as the result of the mental hygiene movement, better training of psychiatrists, nurses, clinical psychologists, psychiatric social workers, and increased public regard.

With me, schizophrenia was slowly and insidiously developed. I was a college graduate, trained for elementary school teaching. I did teach for several years, happily at first, then less and less so. After a few years I just couldn't stand the strain. I loved small children, but I kept falling ill physically and felt myself slipping into a dream world. I stopped teaching and tried other kinds of work in many parts of the country. But it was no use; I couldn't seem to make a go of anything.

I'd even completed a good secretarial training in a business school and had an excellent job. However a frightening gap was widening between me and other people, and I was falling into a vacuum devoid of all feeling. Bewildered, I thought seriously about what to do.

In a daze, I went alone to a psychiatrist, who advised me to enter a state mental hospital. They gave me every sort of known treatment, running the gamut of insulin shock, electric shock, CO^2 treatments, and finally psychotherapy. Because my trouble was recognized late, I had to return to the hospital many times over a period of 10 wasted years. Then everything began to improve.

It was like a play. The stage had to be set, the props placed, the actors told what to do. I was the leading actor without realizing it.

The stage was my environment in the so-called "real" world. The hospital staff decided I could leave if I wouldn't live alone. Since I was in my thirties and unmarried, this meant that mother had to move from her home in a small town to live with me in the city. Luckily, although no longer young, my mother was understanding and willing to make this change.

"Never mind me, dear," she said. "It will be better for both of us to live together instead of alone."

So when we found an apartment I left the hospital and we moved. It was a difficult task. I knew that we must take our time and not push ourselves. I must keep close contact between my real self and the people who mattered. The stage was finally set.

Next we arranged the actors and props of the stage. In order of their importance, these were: Dr. Saitham, my psychotherapist; my mother; Mr. Holliway, my social worker; some steady half-day work; my tranquilizing drugs; and lastly my own firm determination to live as happy a life as possible.

All this may sound easily managed; actually, nothing was easy. The people involved—being human—were subject to ups and downs, I considered myself lucky indeed just to have these people, but it was not luck in the usual sense. I had to remember to keep in touch with them, for if I forgot, I was apt to become a lost soul in a lost world, as I once was. (Even a diabetic will have serious trouble if he forgets to take his medicine or ignores the necessity for doing so.)

First is Dr. Saitham. He is a clinical psy-

chologist working in a tax-supported state clinic. His office is a very modest one; I merely sit across from him during each interview. But psychotherapy once a week with him—we are now starting our fifth year—has done more for me than any other treatment.

To be honest, I don't know just how he has helped me. Psychotherapy, as far as I know, is relatively unproved in worth for schizophrenics since it takes much longer than for mildly troubled persons. Also, schizophrenics usually lack insight, so they say. In spite of all this, I seem to be able to profit greatly by it.

Sometimes I say to Dr. Saitham, "*Why* won't you tell me what you think that dream means?" or, "What do you want me to talk about?"

But he just smiles and answers, "How does it strike you? What are you thinking about?"

Often it doesn't strike me at all. I haven't the faintest idea of the meaning. But I know he wants me not to be influenced by his ideas—just to talk freely, to feel his friendly presence and to discover reasons and explanations for myself. Many times I've left his office angry with him—feeling I might just as well have been talking to myself in a blank room. Later, though, I see why it isn't like being in a blank room.

Even if I never discover *how* he is helping, I know he is always there, always interested in me as a person as well as a case. He is someone standing by, a symbol of steadiness in an unsteady world. At first I was afraid to talk. It took about a year for me to learn to trust him. But now I can speak freely without feeling endangered by rejection, no matter what I say. He is more real to me than anyone. His face is often impassive but he has an understanding heart.

Next in importance is my mother. She is truly remarkable, aside from the fact of being my mother. I'm her only child; we are alone in the world. She isn't young but she is very youthful in thoughts and attitudes. We laugh and joke at little things together; we both like cooking, music and plays on TV.

Naturally we have our occasional disagreements, but I keep her young and she keeps me on the "realistic" level merely by having so much common sense. I visit a few friends my own age and my mother encourages this. She knows the dangers of overprotection. True, I have lost the years and possibilities of a husband, home, and children of my own largely because of this illness, but I am eternally grateful for my mother.

Next is Mr. Holliway, my psychiatric social worker. I had had social workers before, and to tell the truth, I had not thought much of them as a class. But Mr. Holliway was different. He's part of the newly-developed psychiatric "team" in the total push toward recovery of a patient. Here again I am lucky, for there aren't as yet nearly enough good social workers to go around.

Mr. Holliway is a man intensely dedicated to his work and talented in the individualistic approach. When he started to see me for an hour each week in my new home I was greatly surprised and delighted with his help. He, unlike Dr. Saitham, is free to engage in a give-and-take type of conversation about all sorts of difficult social decisions I have to make. We talked over, calmly and objectively, my own ideas about combating the still prevalent rigidity of employers in hiring former mental patients.

"Don't you think," he asked me gently one day, "that it's better to tell a future employer about your illness in the first interview?"

I shook my head. "No. I've been fired twice in the past just because my employer discovered I'd seen a psychiatrist, and I don't think I'd ever get a good job that way."

He smiled and said employers have broader outlooks on the problem these days.

I said, "Yes, I know. Some of them have. But you never know which ones they are until you get into the situation. And I don't feel ready enough to take the risk. I don't want anyone doubtful about me. I want to help remove the stigma, but I don't want to do it at my expense any longer."

He understood and said it was up to me entirely.

Other times we'd talk about social activities. I'm not a social type—perhaps that is why I dislike the term "social recovery." I get along best with a small group or with individuals. He made some suggestions but never pushed me.

So my social activities are confined to going alone—or with a friend—to an occasional play or fine concert, and for two years, I have been enrolled in a very small class in creative writing. With me, a little is good, a lot is too much, and too much includes too many people at once, too many activities in one day, too much excitement. Many of those things aren't too much for many people, but they are to me. I see Mr. Holliway more infrequently now. I know it won't be long before I won't see him at all. I'll miss him but will never forget how much he helped me.

Next, there is my work. That was hard to find—work to keep me busy, work to help us financially, and most of all work that was interesting but not so difficult that it confused or tired me unduly. The main stumbling block in my search was the decision made by the doctors to have me work half-days only. If you've ever tried to find *steady* office work on a half-day basis you'll know what I mean.

I was careful not to jump at the chance of the first part-time job offered me. I looked and looked but it took a full year to find one. Finally one bright September day I found it: a secretarial position in the rehabilitation department of the university hospital. At first I didn't tell them that I'd been (and still was, in a way) a mental patient. I couldn't bear being turned down, for it was just the kind of work I wanted. But after a while I found the director of my department so understanding that I told her.

Her face lighted up. "Good! I'm glad you told me. We like your work and you and now you can finish your rehabilitation here."

I felt very pleased and fortunate to work for such a warmhearted person who was free from prejudice. And I still find it extremely interesting and challenging because I enjoy helping in all kinds of rehabilitation, even in my small way. There is little pressure and I accomplish much work there every morning.

I consider the job just another of my lucky breaks, but Dr. Saitham says no, it is largely the result of my own careful efforts and patience in finding the right thing.

Next were my tranquilizing pills. Much has been written against tranquilizers; those pills are the butt of constant jokes. And the claims against them are generally true for so-called "normal" people. A certain amount of healthy anxiety is needed in order to get things done.

If everyone took pills in order to drift along easily in the face of every small crisis, this world would soon be in a worse state than it now is. But they were prescribed for me by the hospital doctors for an indefinite period. So I take them regularly and they keep me on an even keel.

I take a mild type of tranquilizer that produces no undesirable side effects such as sleepiness, but a large dosage of them daily to reduce tension. Also I take a drug that is supposed to be a "specific" against the hallucinations, or voices that periodically try to work against me. The cost is high but well worth every cent if they keep me living a satisfactory life outside the hospital.

The last of the actors is myself. Dr. Saitham keeps insisting that it is I myself and my own great efforts that are the most important. I can't agree with him. (One of the greatest satisfactions I find is this freedom to be able to disagree amiably without also feeling vaguely insecure about the whole thing—as if I'd somehow lose his respect and help if I didn't agree.) I know that all the other supports would be useless if I didn't have a great drive to help myself. But I can't help thinking that all are dependent upon each other.

It's true that I still have short periods of setbacks, periods of temporary confusion when my two opposing worlds of reality converge into a sometimes dim, somtimes vivid dream life. During those times I feel lost. Everything looks unreal except the forms and shapes of what others call my imagination. My thoughts go one way, my emotions go another way and my actions still another. There is no fusion. But these periods are getting shorter and perhaps someday they'll disappear altogether.

I'm glad that, for me, this nightmare life, when it becomes dominant, is never pleasant. I hate it intensely, so I have something to fight against. To many schizophrenics it is a pleasant experience, free from all difficulties and responsibilities, and they tend to remain in it longer. But I want to avoid it. I know I must fight it with all I've got in order to survive.

It is a marvelous thing to realize that recovery is now possible for schizophrenics, even for so-called "hopeless chronic" cases like myself. I know I have to live on a lower emotional and physical level than many people. But I'm usually content, just as are many physically handicapped persons who've at last found acceptance by the world on their own merits.

It's really true that "half a loaf is better than none"—no one knows this more than I do. Nothing is hopeless unless the individual himself gives up trying. And nothing worthwhile is ever achieved without sacrificing many things.

MILDRED W. BARKSDALE, Ed.D.

Social problems of mentally retarded children

It is generally agreed that mentally retarded children have more problems of personal and social adjustment than normal children. In a discussion of adjustment problems of the mentally retarded, Sarason[1] states that "his perception and understanding of his environment and his handling of interpersonal relationships are aspects of functioning in which the retarded child differs from his normal peers."

The retarded child's behavior is often the consequence of many frustrating experiences he has had both at home and in school because he is regarded as a failure. Many of his personal and social problems arise from the extent to which he is misunderstood by others.

Several investigators have reported that mentally retarded children are socially segregated in the regular grades of both traditional and progressive school systems, even though they are physically present.[2] In another study it was found that among children enrolled in special classes there were degrees of social acceptance; some of these pupils were highly accepted by their classmates and some were not.[3] It appears that the class placement of the mentally retarded child does not resolve the problem of his popularity or lack of it.

This article is concerned with three

Dr. Barksdale is assistant professor of education at Atlanta University, Atlanta, Ga.

[1] Sarason, Seymour, B., "Mentally Retarded and Mentally Deficient Children, Major Psychological Problems," in Cruickshank, William M. *et al.*, eds., *Psychology of Exceptional Children and Youth* (New York: Prentice-Hall, Inc., 1955), 454.

[2] Johnson, G. O. and S. A. Kirk, "Are Mentally Handicapped Children Segregated in Regular Grades?" *Journal of Exceptional Children*, 17(December, 1950), 65–68.

[3] Turner, Mildred White, *A Comparison of the Social Status of Mentally Retarded Children Enrolled in Special Classes.* Indiana University, 1958. An unpublished Ed.D. dissertation.

questions which may enable teachers to help mentally retarded children develop social habits and attitudes which will contribute to more satisfactory personal and social adjustment:

1. What kinds of behavior do popular mentally retarded children display?
2. What is the social maturity status of mentally retarded children?
3. How do mentally retarded children rate with their teachers?

A sociometric test was given to 390 mentally retarded children enrolled in special classes in elementary schools of North Carolina in order to determine their social status in their class. A total of 94 pupils received 15 or more choices on the test—these pupils are referred to as the *popular group*. There were 113 pupils who received three choices or less and constitute the *unpopular group*. When children made a choice they were asked to tell why they chose the child named. The most frequently mentioned reasons they gave for choosing members of the two groups are presented in table 1.

TABLE 1

Reasons pupils gave for choosing members of the two popularity groups

Reason for choice	*Number of times mentioned*	
	Popular group	*Unpopular group*
1. Is nice and friendly	210	10
2. We like to play together	200	10
3. Doesn't fight	160	..
4. Is my best friend	150	12
5. Is very kind	140	..
6. Lives near me	113	40
7. Knows how to play	102	..
8. Helps me with my work	70	..
9. We share things	60	8
10. We like the same things	45	15
11. Plays fair	40	..
12. We get along all the time	37	..

The data in Table 1 show that being nice and friendly and compatible in play were the most frequently mentioned characteristics of pupils in the *popular group*. Nonfighting, friendship, kindness, and propinquity were other characteristics attributed to this group. Nearness in place of residence was the highest ranking reason given for choosing pupils in the *unpopular group*. These findings suggested that teachers should carefully observe children for signs of behavior which contribute to lack of popularity. After these signs of undesirable behavior are detected the teacher can judiciously provide opportunities for unpopular children to develop more desirable social traits.

The Vineland Social Maturity Scale social quotients shown in Table 2 indicate the difference in social maturity for the two groups studied. The t-ratio for the difference between means was 2.78, which was significant at the 1 per cent level of confidence. This evidence of greater social maturity among popular children suggested that pupils' acceptance by peers could be increased by helping them to develop more of the behaviors and skills measured by the Vineland Social Maturity Scale.

The teachers were asked to indicate their preferences for pupils enrolled in their classes. These data are reported in Table 3. First choice meant that these pupils would be most preferred if teachers had an opportunity to choose pupils for their classes. Third choice meant that pupils would be least preferred if teachers could select class members.

The chi square of 1.654 was not significant at the 5 per cent level of confidence. The difference found in teacher preferences for having popular and unpopular pupils in class could have occurred by chance alone 80 times in 100.

TABLE 2

Comparison of social quotients for popular and unpopular groups

Social quotients	Popular group		Unpopular group	
	Number	Per cent	Number	Per cent
95–99	7	7.5	5	4.4
90–94	7	7.5	3	2.7
85–89	8	8.6	8	7.2
80–84	10	10.8	18	15.7
75–79	23	24.7	25	22.1
70–74	19	20.4	17	15.1
65–69	9	9.7	16	14.0
60–64	7	7.5	8	7.2
55–59	..	...	5	4.4
50–54	3	3.3	8	7.2
Total	93		113	...
Mean	78.10		75.90	...
Standard deviation	10.50		11.00	...
t-ratio	2.78			

CONCLUSIONS

1. Placement in special classes does not assure mentally retarded children of social acceptance among their classmates.
2. Some mentally retarded children need specific help in developing behavior which will improve their social status among their peers.
3. Popular mentally retarded children had significantly higher social quotients than the unpopular children.
4. There was no significant relationship between popularity of pupils and teacher preferences for having them in class.

IMPLICATIONS

Teachers can help pupils improve their mental health by attacking some of the problems affecting social and personal adjustment. Acceptance by others is important regardless of mental level. By careful study of behavior that causes lack of popularity teachers can help pupils

TABLE 3

Teacher preferences for popular and unpopular pupils

Popularity group	Observed frequencies			
	1st choice	2nd choice	3rd choice	Sum of rows
Popular	59	22	13	94
Unpopular	63	27	25	115
Sum of columns	122	49	36	207
Degrees of freedom	4			
X^2	1.654			
P	.80			

eliminate these characteristics and develop more desirable social attributes.

Although there were no indications in this study that the number of choices received on a sociometric test determined a pupil's acceptance by his teacher, it would be wise for teachers not to become immune to the fact that a child may not be rating too well with his peers just because they like the child.

Good mental health is too important to be left to chance. It thus becomes necessary for the teacher to explore all possible sources of social and personal problems in order to effect the best adjustment for the child.

RUBY A. PALMER, R.N., B.S., M.A.

Some considerations of acting out behavior in nursing situations

The acting out of patients on a psychiatric ward can be considered a behavioral mode of expression which is a substitute for verbalization of unconscious motivating forces or repressed material of an individual's psyche.

These behavioral expressions often take place outside the doctor-patient interview situation and are data which can become lost to the psychotherapist. The function of the psychiatric nurse in discerning and retrieving information in regard to behavioral transactions and interchanges in a ward setting has not been too clearly defined. This paper will focus primarily upon the observational and perceptual functions of the psychiatric nurse in providing information through the medium of feedback.

Acting out behavior can be conceptualized generally into two reference frames: one, a regressive defense and the other, a constructive defense or movement. That is to say, behavioral expressiveness may be stimulated by the unconscious desire or wish of a patient to recapitulate infantile or childhood experiences as a profound attempt to gain the security experienced in earlier situations.

Or, the behavior may be an attempt to resolve or master earlier conflicts through fantasy or distortion of the real-life situation. Here, efforts are made to strengthen the ego by mastering the material world through utilizing self-protective devices designed to maintain and promote self-esteem.

Often the case may be that the awareness of repressed material brought about by the

Miss Palmer is an instructor in psychiatric nursing, School of Nursing, University of California Medical Center, Los Angeles.

session with the therapist will remobilize anxieties and inner conflicts and cause the patient to retreat to former infantile patterns of behavior. The particular form this regression takes, the timing and the situation related to its occurrence, can be data which the therapist may need to test out the validity of his interpretations.

The behavior of the patient on the ward may be significantly related to the psychotherapeutic process between the therapist and the patient. Much will depend upon the perceptual and observational skills of the nurse and on her communication of meaningful feedbacks to the therapist. To whatever end the acting out behavior is directed, it allows the patient's problems and intrapsychic processes to become manifest and thus more amenable to cognition.

The inability of the patient to communicate the nature of his difficulties directly to the therapist retards the progress of his treatment. However, material necessary for a better understanding of the psychodynamics of the patient is communicated indirectly or symbolically in interpersonal transactions with the nursing personnel. The intellectual operations employed by the nurse, together with her perception of what is occurring, can realize the value of the data she is observing and experiencing.

Three characteristic situations will be selected from a ward setting in order to illustrate the application of this function of psychiatric nursing.

First, the behavior of the newly admitted patient will be considered to demonstrate how the process of hospitalization itself can be assessed for its clinical significance. The reactions of the patient when first admitted—especially those regarding motivation for hospitalization—may be lost unless retrieved and captured by the nurse for what they are. Later behavior can get contaminated or hidden with sophistication or defense against therapy.

The reasons that people seek help or hospitalization need to be appraised. Fantasies, thoughts and feelings which patients have about the hospital and the expectations or fears they may have of the therapist can be reported skillfully by the nursing staff.

The actual entry into the hospital may be a symptom which is often discerned upon admission. It may represent a flight from responsibilities, under the blanket of illness. This kind of manipulation device gives the patient an opportunity to escape from intolerable situations to the haven of the hospital, where anxieties and pressures of reality are taken away. Observation of the patient's first reactions upon hospitalization can sometimes reveal information relative to his motivation for entry.

Some patients seek hospitalization as an end in itself, a forevermore sanctuary from the completely frustrating experience of life, from responsibility and from living with other people. Sickness can be rewarded through relief of overwhelming pressures and thus perpetuated. The pressures of these reality factors are often observable in the acting out behavior of newly admitted patients and family or friends who accompany them to the hospital. Clews can be picked up by the nurse who is sensitive to the situation.

The following example of a newly admitted patient will illustrate the kind of observations which the nurse can make that are helpful to the therapist:

A young lady who had recently had her third child began to act in a rather bizarre way at home. She was unable to attend appropriately to her children or home responsibilities and became progressively more withdrawn and apart from her sur-

roundings. Her husband, worried by her behavior, took her to a psychiatrist who saw her on three occasions in his office and on her last visit recommended immediate hospitalization.

Upon admission—accompanied by her husband—she was distant and remote in her verbal responses and appeared depressed in her physical and facial expressions. Her distraught husband readily explained to the nurse that his wife was unable to care for their children or the housekeeping necessities, that he feared she was neglecting the new baby and that she might even do the baby harm since she was acting so strangely.

He was very anxious and blame of his wife, brought on by his fears, was evident in his tone of voice and mutual withdrawal from his wife. He was eager to get her into the ward and into the hands of the staff, and his relief from the responsibility of coping with his withdrawn wife was evident by his hurried exit and distant good-by to her on his departure from the ward. The patient began to cry after her husband left and expressed her resentment of the psychiatrist for causing her admission. She repeatedly murmured, "I don't understand what it's all about."

Later the therapist explained to the nursing personnel that he was able to utilize the observations made of the reactions and communication on admission between the husband and wife as a way of dealing concretely with the patient's feelings. She felt abandoned by her husband because of his attitude, and the psychiatrist was able to explore the psychological meanings underlying this fear of abandonment with her toward a gradual awareness of her transfer of childhood feelings about her own father to her husband and her therapist. The guilt she experienced because of her inability to accept the responsibilities of a mother and a wife were traced to her feelings of inadequacy.

The motivation toward illness as a solution for her problems was emphasized by the therapist as one of the significant aspects he considered in her subsequent therapy.

The particular and pertinent observations of the nursing staff during the admission procedure were considered as highly contributory factors in helping to provide the therapist with some reality situations which he could utilize to work through in order to get at deeper underlying conflicts.

Contrasting this type of communication with some of the less informative routine types of observations recorded on charts illustrates the importance of communicating what is often observed but usually forgotten by the nursing personnel.

Before acculturation by staff, other patients or the hospital system, takes over, the therapist will benefit from early observations of the patient's acting out behavior. The patient is often the presenting part of a deep family conflict, and signs of this may be observed in initial behavior on admission. The relief of stress through hospitalization can bring about reduction of symptoms which in turn will minimize the possibility of helping the patient work through the anxieties of the realities in his life situation.

A second consideration to illustrate meaningful feedback is in the area of transference. The phenomena of transference and counter transference are not restricted to the therapy hour. The acting out behavior on the wards needs to be understood if transference manifestations are to be picked up and communicated for use in therapy. This behavior can be an indica-

tion of how the patient sees his therapist.

An example of this can be observed in the depressive illnesses where the dependency factors are dynamically significant. The nursing personnel may be the only avenue by which indications may be sensed as to the impact on the patient of an impending discharge.

The loss of the hospital through discharge can represent a loss of the therapist. Fears of desertion may be reactivated and acted out in ward behavior. The therapist will want to take these transference aspects up with the patient as a safeguard against return of suicidal thoughts which often occur in the weeks following discharge and which sometimes terminate in the death of the patient by a successful suicidal act.

In order to understand and correctly interpret distortions, the therapist may need the particular data of the transference which occurs outside his relationship with the patient in order to use it as an instrument in his therapy. Interpretations made by the therapist to the patient about his everyday behavior and relationships with others can be better understood when taken up within the context of his ward behavior.

Other situations in which the subtleties of the transference and counter transference reactions may be perceived by the nursing personnel can be observed in the manipulative devices acted out by patients.

The following excerpt from a ward event will serve as an example of this phenomenon:

A very hostile young female patient verbally attacked the nurses for insisting that she get up and dress during the day. She accused them of not knowing how to appreciate her need to have privacy and informed them that she did not come to the hospital to be ordered around by a group of nurses who "wouldn't understand." Later in the day this patient would dress and attend patient groups where she made a very good social adjustment to the evening activities.

She conversed generously and amiably with the other patients and related particular episodes which demonstrated how cold and disagreeable the nursing staff was to her. The special skill with which she weaved ward events created anxiety between the patients and personnel. Her hostility toward the therapist was well-known, too, and the free-floating blame—thinly veiled, staff against staff, patient against staff and staff against patient—began to disrupt any concerted therapeutic attempts to deal with her behavior.

Later in team conferences many facets of this manipulation were identified for their destructive effects. The anxiety surrounding the patient's great need to deny her feelings of identity with her sex was converted into aggressive, hostile behavior against the female nurses. Her method of belittling and degrading them was a projection of her own self-depreciatory feelings as a woman. Her own mother deserted her as an infant and she never knew her father's identity.

The resentment and anger she directed toward the therapist was seen as projected blame on this representative father figure. As the explanation underlying this woman's behavior unfolded through discussion, the nurses began to identify and recognize their reciprocal hostile actions toward the patient, actions which they had carefully concealed, even from themselves. She provoked defensive reactions by attacking their professional worth and identity.

This process lessened their perception of transference manifestations wherein they

were seen as the illusory mother or as the projected inadequate female self. The further distortions of the transference-counter transference manifestations were studied through the detection of the snowballing effect of blame which spread throughout the ward relationships. The focus of everyone blaming everyone else for the ward disruptions became apparent. Once the blind spots in the perception of what was occurring were worked through and the individual problems of identity were illuminated for the staff, a more therapeutic approach was devised to deal with the acting out behavior of this patient.

Subsequently, the content of the ward behavior was used as material for a therapeutic tool in the doctor-patient therapy sessions, where beforehand it had been lost through distortion brought on by staff anxiety.

A third characteristic situation will further illustrate the contributing function of the nurse, as described in this paper:

Many adolescent patients are provocatively rebellious toward living. This negativistic or attention-getting device, which resembles the frustration of growing of very young children, creates ward managerial problems for nursing personnel. This acting out can be stimulated by the youth's attempt to handle the anxiety created by the intense feelings engendered in his close relationship with the therapist.

As the possibility of his own personal worth or validity as a person in his own right begins to emerge into awareness, the patient may re-experience early doubts and fears as to the wisdom of expressing his real self and feelings lest he be rejected again by a restrictive parent. Afraid to truly test this possibly benign yet potentially rejecting father figure, he will act out his insecurities on the ward either as a testing device to see if he can really be accepted for himself or as an attention-getting mechanism to safeguard recognition, however distorted or tenuous, for his own security.

This re-establishment of childhood behavior patterns, whatever the underlying purpose, does pose a management problem. Reaction and angry responses by the staff to uncontrolled infantile or childlike behavior by a young man—who has demonstrated in other instances that he can act more maturely—sometimes results. Punishment or rejection as a type of management can lead to guilty feelings or justifying explanations on the part of the nurse. Selective attention can occur and the behavior fails to be observed for what it is and perceived as meaningful information for use in therapeutic sessions. Rather, it can be ignored as though unrelated to the patient's psychotherapy or unreported because it is painful to admit or even to recognize angry responses.

The foregoing illustrations have been explored not for the purpose of interpreting the patient's unconscious intrapsychic processes but to demonstrate the potential of nursing personnel in handling their responsibilities in the service of psychiatric patients.

The unconscious motivation of the patient causes him to act out feelings which he cannot relate directly. In order to help him become more consciously aware of the ineffectiveness or destructive-maintaining nature of his current interpersonal relationships, the therapist can draw from the current patterns of his personal functioning with others to help him discern meaningful connections between early childhood experiences and present modes of behavior.

This paper has focused on only one as-

pect of the function of the psychiatric nurse. These perceptual and observational skills are related to other skills which the nurse utilizes in the care of the psychiatric patient, and they are an integral part of her over-all functioning. A new dimension of critical inquiry into the basic observational skills is certainly not a new innovation but one that needs to be developed.[1]

[1] The writer is indebted to Dr. T. S. Main of London, England, for pointing up the need for developing this particular aspect of nursing care.

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MARY G. MONTEIRO, M.S.W.

LILLIAN M. SNYDER, M.S.S.

Social therapy through hospital ward discussions

Considerable attention has been given in recent years to the therapeutic significance of the emotional climate on the ward. For the patient in a hospital, the ward becomes his home. Providing patients the opportunity to deal with their problems through hospital ward discussions appealed to two social workers and the chief psychiatrist in a general hospital as one way of minimizing some of the distressing influences which tend to retard recovery.

Sparked by conversations with Dr. T. P. Rees,[1] who expressed great enthusiasm for the value of ward discussions at Warlingham Park Hospital in Croydon, England, we attempted to find descriptions of similar uses of ward discussions in general hospitals.

A search of the social work literature and personal inquiries of social workers revealed very little on the use of the group method in the general hospital. We studied what we could find on the general subject of the group approach to define a group method consistent with our training and experience. A list of these references is included at the conclusion of this paper.

On November 22, 1954, two social caseworkers initiated group discussions for patients on eight wards in a general hospital providing medical and surgical treatment for the acutely ill. In this hospital, a ward consisted of about 50 beds, some of which

Miss Monteiro is a clinical social worker at the Veterans Administration Hospital in Baltimore, Md.: Miss Snyder is a research associate, Maryland Commission on Alcoholism, Baltimore.

The authors are solely responsible for the opinions expressed in this paper.

[1] Dr. Rees is former superintendent of Warlingham Park Hospital, an open-door psychiatric hospital located in Croyden, Surrey, England.

were located in small rooms near the nurses' station. As the patients progressed, they were moved into a large wing which accommodated about 30 beds. During this period, there were approximately 280 patients in the hospital on any given day.

The number of patients participating in the group discussions averaged from eight to twelve, with a range of attendance from two to thirty. About half of each group consisted of new patients.

The group discussions begun in November continued at weekly intervals until June. We trust that the following account of this six-month experience will be useful to others who may be considering a similar approach.

PURPOSE OF WARD DISCUSSIONS

The purpose of initiating group discussions on the wards was to provide an opportunity for patients to ventilate their feelings and to help each other in dealing with immediate stress situations which might retard recovery. For psychiatry, this technique extended an opportunity for furthering the therapeutic climate which hopefully would prevent or minimize abnormal emotional disturbances. For social work, the discussions provided the means to assist patients in dealing with some worries at their onset, thereby making better use of the limited time available by social work staff for social casework.

Discussions between the psychiatrist and key members of the hospital staff laid the groundwork for the experiment. Some objections arose. One was the fact that the groups might hamper the doctor-patient relationship. Some felt that the doctor alone should handle all the patient's problems. Others felt that such discussions would degenerate into "gripe sessions," thereby interfering with the routine care of the patient. Some of the young and inexperienced staff members were fearful. The majority remained to be convinced.

On the positive side, many welcomed such techniques, hoping they would alleviate intragroup tensions. Some felt that this would encourage patients to solve many of their own problems merely by taking this opportunity to raise questions which could be answered within the group itself. Others felt that this technique would indicate the emotional pulse of their respective wards in response to the impact of the hospital on the patient. The nurses, in particular, felt that they might learn more about the patients' needs in areas other than purely physical care.

Some anticipated that the experiment would result in bringing all the hospital staff on the ward closer together in the combined effort to help the patient get well.

Although the caseworkers had felt uneasy in undertaking the group discussions without training in social group work, they were very much relieved that the groups carried themselves. The fear that the patients would be indifferent or that the group discussions would get out of hand were groundless.

INITIATING THE WARD DISCUSSONS

The ward discussions were begun on all wards during the same week with the view to exerting the maximal influence on the emotional climate of the total hospital.

On the morning preceding the first discussion, each social worker invited the patients on her ward to attend the group. This invitation was informal, merely informing the patient that a discussion group was going to be held on his ward every week at 3:00 P.M., so that patients might get better-acquainted with each other and bring up whatever they cared to talk about.

One head nurse suggested that patients who brought up personal worries during the nurse's early morning ward rounds could be reminded about the ward discussion group with the social worker in the afternoon. Some patients were skeptical. One said he didn't like to go to meetings; he could take his gripes to the union meetings. Another patient, a merchant seaman who had been at sea for 20 years, said he didn't like to talk and was less interested in hearing others talk.

It was observed that frequently after visiting hours there was a natural tendency among patients to assemble in small groups to play cards or to compare reactions to events of the day. On the first day this natural group became the nucleus of the ward discussion. The group assembled around the bed patients. The social worker opened the discussion by introducing herself and stating the purpose of the group session. There was a natural tendency among the patients to share feelings and experiences.

The group served as a means for the social worker to observe the behavior of the patients in the group and for the patients to observe each other. As the leader, the social worker set few limits in the discussion. This provided the opportunity to observe the withdrawn patient or the hostile managing patient. Discussion centered on the patient and his relation to his environment—on the ward, the hospital, his boss, a compensation board, his family or his future. Some patients gave each other support. For example, older patients prepared younger ones for an operation. Worries patients brought with them were of major concern.

At first, some patients competed in making complaints about hospital routines, attitudes of staff members, Congress, and finally about each other. Some complained about the food. For example, one patient complained that his doctor had put him on a diet which he interpreted as a form of punishment. Others complained about being awakened at 6:00 A.M., when they were not served breakfast until 8:00 A.M. After reading about a hospital fire, some felt that the hospital should have fire escapes.

Many persons expressed anxiety about the ambulatory stage of their illnesses, following surgery. Difficulties with routines were felt much more by the recuperating patients who were not ill enough to remain in bed but too sick to leave the hospital. The group served to point up the need for further explanation of some hospital procedures. For example, a few patients stated they would like nurses to explain, briefly, whatever papers they asked patients to sign. They were willing to sign the papers but complained that the nurse was too busy to allow patients to take the time to read them.

Patients identified procedures which could be improved. Some expressed a need for more frequent visits by the clergy and for more extensive use of the patients' library facilities in the evenings and on weekends. The most prevalent need expressed by all patients was for a more extensive recreational program which would include movies, social hours, organized games and organized physical exercises. Some were interested in taking correspondence courses. Stating the complaint lessened its severity.

Many of the discussions centered on the doctor-patient relationship. Some patients felt that the doctors were too busy to see them. Others felt a close relationship with their doctors. One patient commented, "The doctors here tell patients more about their illness than any place I've been. They are very understanding." Some felt that they would be more comfortable if

they had an opportunity in the group discussion to talk about medical and nonmedical aspects of their illnesses with their ward physician. They seemed to want more explanation.

Complaints lessened as the series of ward discussions progressed. Just as each group meeting frequently began with an expression of dissatisfaction and progressed toward a sense of well-being through exchange of opinions, this process was a miniature of the six-month series of discussions. Complaints were balanced by praise. Nursing care was consistently praised and some patients volunteered to assist the nurses in saving steps.

Patients frequently raised the question, "What is social work?" There was great concern about the delays in recovery. There were questions about the relation between the length of hospitalization and the severity of the illness. For example, one patient who had no symptoms complained that he had been in the hospital for seven weeks. Others reassured him he had no grounds for complaint if his stay now would minimize the likelihood of a preventable disease.

Many financial problems were brought up by patients who were worried about their wives and children. The relationship of disease to social stress and family crises was frequently brought up. Some were unable to return to their jobs. Others had to change many lifetime habits in adjusting to a chronic illness, such as tuberculosis, diabetes, heart condition or alcoholism. Whenever any of these questions arising out of the group discussions were not easily answered, appointments were made for individual interviews.

By dealing with emergencies as they arose, there was a marked decrease in the number of emergency referrals from physicians when they discharged their patients. The social workers felt that group discussions had been a source of discovering patients in need of casework therapy early enough to deal with many troubles early in process of recovery.

An interesting observation made as the meetings progressed was that both the patients and the social workers used the group to meet their own unconscious needs. One of the social workers, formerly a school teacher, used the group as a question and answer session. The other social worker used the group in a crusade for recruits for the vocational rehabilitation counselor. Collaboration with the chief psychiatrist provided insight and direction for the social workers in achieving goals.

COLLABORATION WITH CHIEF PSYCHIATRIST

Preparation for the ward discussions began during the regular weekly conferences between social workers and chief psychiatrist about two and one-half months before the first group meeting. For several years one of the social workers had been interviewing tuberculosis patients in groups.

A popular series of mental health film discussions attended by medical staff, wives, ward personnel and a few patients, at the invitation of the Social Work Department, had been concluded at the beginning of the summer. Review of these experiments in improving social climate among staff and patients led to mutual agreement to initiate ward discussions.

Summaries of the ward discussions were dictated by the social workers immediately following the sessions and typed by a volunteer. The goal in recording the summaries was to capture the group interchange and tones of emotional response as well as reactions of social workers. Occasionally a verbatim report of a patient's remarks uniquely portrayed the emotional response

of the group. No notes were taken during the sessions.

These brief summaries were used as guides in analyzing the social worker's use of herself in the group during weekly conferences with the chief psychiatrist. The necessity for maintaining a permissive and uncritical attitude on the part of the social worker was emphasized. There was also some exploration and examination of the social worker's concept of her role and her feelings in this type of relationship to group members. Considerable attention was given to ways of dealing effectively with the tendency for the group discussion to take on the tone of a mere "gripe" session or an academic question and answer period.

One social worker was surprised to observe that patients participating in her four wards during the first week seemed very gentle. They were protective of her. She reasoned that patients were hesitant to expose themselves to the group. Further exploration of this hesitancy in discussions with the psychiatrist revealed that the worker had difficulty in releasing her control of the group.

Discussions with the psychiatrist revealed the tremendous significance of the ward life to each patient. Each ward represented a unique community for each patient living on that ward. Just as there is variation in emotional tenor from community to community, there was a similar variation in emotional climate from ward to ward, which in turn had its significant effect on the feelings of the patient.

It was felt that the curiosity and interest among staff members on each ward in the group discussion had a beneficial effect on that ward. The social workers became members of the ward community, and patients felt increasingly free to bring up any troubles within hospital or personal life hampering their recovery in any way.

ILLUSTRATIONS OF WARD DISCUSSIONS

December 3, 1954

When worker walked down the length of the ward stating that there was to be a discussion group, a patient stopped her to say he wanted to talk with her about these groups. He had heard that they were being held on various wards and he did not think there was any need for these group discussions. "The first thing you know they will be just like the union meetings. Some fellows," he said, "are just waiting for a chance like this to start beefing. Anybody who finds fault with this hospital does not deserve to be here."

Discussion

There were five patients in this group. One was a bed patient. One young man said that he would soon be discharged and was very happy about it because he had been here four weeks. He said that everything had been more than satisfactory, but that "as soon as you are able to get around you like to leave the hospital." All of the patients in the group agreed with one another that things could not be better. One of these patients said, "You have to remember that this hospital is badly understaffed and if you have to wait for something, it isn't the fault of the people who are working on the ward. It just isn't possible to take care of everything when there are not enough people."

There was some discussion of consultants and why they take so long to see patients. One patient said that he has to have a myelogram and has been waiting for Dr. X for four weeks. Nothing can be done until Dr. X sees him. While he has been waiting, he developed an infected finger and now has to stay in bed. He explained that he was not the only patient who has been waiting since there are several others in the ward who are also waiting to be seen by Dr. X (an extremely busy surgeon who finally examined patient and recommended surgery).

These patients were especially interested in hearing of the services of the Division of Vocational Rehabilitation. One patient described the Alcoholic Anonymous groups (which were held on Monday and Thursday evening within the hospital) explaining that although he was not an alcoholic, he attended the meetings because he liked the philosophy and could use it. He felt that since there are so many people who need help with drinking problems that it is good to know where they can get help if they want to stop drinking.

Another patient told how the AA had helped him.

At the end of the discussion, one patient said that he thought it would save the worker a lot of time if these discussion groups were held in a large room so that patients from several wards would come. He felt that the ward personnel should go around to announce the meeting. He felt that these discussions help a patient to learn more about the hospital and the services available.

February 24, 1955

There were six patients in this group; two were bed patients.

Discussion

This was a very lively discussion. The patients talked of the various injuries that seamen incurred on board ship or in industry.

One patient had filed his claim with a compensation board and had been advised to come to this hospital, but had heard nothing else. He wondered how and when it would be decided if he had a just claim. The patient had a great deal of feeling about this, since he had been incapacitated for a long time.

One of the seamen said that he thought persons on shore must lead very dull lives by working on jobs having very little variety—always being ashore and coming home every night. Another patient said that he thought that this was pretty nice. He spoke of the advantages of such a life, of the fact that a job is not dull; it is what you make it. And the coming home every night is not dull, as that too is what you make it. There was some talk of the value of family relationships, and one of the seamen felt that being married to a woman who could influence your life was a great hazard.

April 15, 1955

Seven bed patients and four ambulatory patients joined in the discussion. Two patients had been present in previous sessions.

Discussion

The first patient opened the discussion with the question, "Why don't the nurses like me?" Another patient explained that the first patient had just come back from an operation and the doctors had complained to the nurses that they fed him tomato juice. Patient, however, denied this. No one could explain the situation, but apparently the patient was rather pleased that he had caused a commotion. Other patients pointed out that this man who felt persecuted seemed to be a favorite with the nurses.

Discussion then centered on the services of the Division of Vocational Rehabilitation. Several patients appeared interested.

One man then brought up the fact that he did not like to have the television on as it was always too loud. Although the television was at the other end of the ward, he pointed out that even during the discussion it was on quite loud and no one was listening. He compared this hospital with another hospital where the television is located in an auditorium and anyone can go to listen; it does not disturb the patients who are ill.

Another wondered if it were ever possible for all of the patients to get together. He brought this up several times and pointed out that in other hospitals it is possible for all of the patients to get together.

A group member asked how a man over fifty years of age could get a job. This brought up considerable discussion. Another patient stated that his company had promised him a job for the rest of his life because of the many risks he had taken during the war.

One patient wondered why he had to take so much castor oil. He added that his meals do not do him any good as he was losing about two pounds every day. There was a great deal of active discussion, which the patients seemed to enjoy thoroughly, and the group did not break up when the social worker left.

OBSERVATIONS

From the beginning of the group discussions, an attempt was made to determine objective criteria which might be used to evaluate the effectiveness of the group method in improving the therapeutic climate on the wards. Certain observations might be noteworthy:

1. Could regular attendance be used as an indication of the patients' need and desire to participate in the discussion groups? Attendance varied from two patients to thirty. At times, less than 50 per cent of the beds on the ward were occupied at the hour of the group meeting. Some of the group members occasionally had to leave before the end of the sessions to get medication or treatment. Attendance,

then, did not seem to be suitable as a criterion to measure the interest in or effectiveness of the group method, but it was gratifying to see the increasing number of returnees.

2. Might the size of the group be any indication of the value of the technique in influencing patients as well as ward climate? Patients who participated in small groups of three or four appeared to benefit as much as those who participated in larger groups. Even two or three patients would often bring up problems which concerned the entire ward. A small number of patients could effect some change. Change could result, therefore, regardless of the number of patients participating.

3. Would the statements patients made at the end of each session give some degree of measurement of results? At the end of almost every session, several patients expressed appreciation for the opportunity to bring up subjects that had been previously unresolved. One patient summed up his impression of the discussions, "It makes you feel the hospital is interested in doing more than passing out pills."

4. What were the reactions of the staff nurses and ward physicians? Several head nurses observed that the patients were less demanding, less irritable, and less apprehensive. Although some of them attributed this to the weather, and others to the fact that apparently there was a more mature group of patients being admitted to the hospital, others felt that the change in attitudes of patients was a direct result of the group discussions.

On several occasions, the head nurse went to the extent of rounding up the patients and joined them in the discussions as she felt that the discussion groups were an important part of the total treatment, especially among the tumor patients who remained in the hospital for many months.

From time to time, some of the ward physicians, examining new patients within earshot of the group, commented that they were surprised that the patients would participate as enthusiastically as they did. Some of the doctors felt that consideration should be given to any suggestions that patients made to improve their hospitalization. One physician wondered about the possibility of using the method himself in the outpatient clinic.

Comments among the physicians frequently heard were, "It's a useful experiment." "Emotions are contagious, and when patients can get a few worries off their chests, they are more amenable to medical care." "It saves the doctor a lot of time as he is too busy with other responsibilities to listen enough to patients' troubles." "More attention should be paid to interpersonal relations." "Many things about my patient came to my attention which otherwise might have gone unnoticed."

5. What was the effect of the group discussions on the caseload in Social Service? Approximately 80 patients per week were reached in the ward discussions. There was a decrease in the number of "minor service cases" referred to social workers during this period. Many patients seeking answers to some of their day to day problems were able to raise these questions in the group.

The discussions stimulated questions from others in the group early in their hospitalization. Patients were assisted with many social difficulties immediately and by the end of the six months there were few emergency referrals at the time of discharge. More time was available, therefore, for intensive casework service.

The ward discussions enabled patients

to take more responsibility themselves in their own physical, social, and emotional recovery. Moreover, some patients, stymied by fears and worries resulting from illness, asked to see the social worker alone following the group discussion. These patients might not have been referred to a social worker or might have been referred so late that worry about their home troubles, for example, might have stood in the way of a needed operation.

6. What was the effect of the discussion group on the psychiatric services? By talking out fears in anticipation of changes in behavior or habits following surgery or medication, the discussions provided a means whereby patients were able to assist each other in recovery.

For some there was diminution in the degree of apprehension regarding the nature of psychiatric services. These patients made better use of their psychiatric referral than they had in the past. Some initiated the referral themselves.

7. The hospital administrator saw value in the group discussions as an administrative tool in getting information about the general attitudes of patients toward their total medical treatment.

The groups, for example, can serve as a substitute in revealing attitudes and information which many doctors believe may be obtained only through the medium of personal experience as a patient. The administrator pointed out further that complaints of some patients may be a reaction to some of the problems of interpersonal relations among staff members.

There was general agreement that the experiment in the use of group discussions did significantly enhance the therapeutic climate of the wards. Although we were unable to graph the results of our experiment on a chart, the insights we gained into the possibilities of the social work contribution to therapy of patients in the general hospital were gratifying.

The many evidences of successful results lead us to support enthusiastically Dr. Rees' statement on the value of ward discussions and we hope that our experience will encourage further experiment in the same direction. By coming out of their offices into the hospital community, social workers can focus their knowledge and skills on a useful vehicle to promote social interchange among patients and staff.

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ROBERT E. SWITZER M.D.
J. COTTER HIRSCHBERG, M.D.
LEILA MYERS, M.S.W.
ELIZABETH GRAY, M.S.
NATHANIEL H. EVERS, PH.D.
ROBERT FORMAN, M.D.

The effect of family moves on children

Americans are truly on the move! The U. S. Department of Commerce and Bureau of Census (1) reports that one person in five, over one year old, changed his residence between April 1, 1956, and April 1, 1957. A more recent report by the National Education Association (6) indicates that 40 million Americans move every year and that an average of one family out of every four changes homes every year.

Findings from several studies (2, 6, 10) about moving show that: farm families are the most stable; movement is toward the West; school-age children move somewhat less frequently than children in the one-to-four age group; young families (in their twenties and early thirties) move more often and farther than others.

Migrant labor is a negligible factor. There seems to be a definite caste system emerging (Levittown cited as an example) (10). Family attitudes toward moving are definitely changing. Young families are

Drs. Switzer, Hirschberg and Forman are all associated with The Menninger Clinic, Topeka, Kan. Dr. Switzer is director and Dr. Hirschberg, training director, of the Children's Service and Dr. Forman is a staff psychiatrist. Mrs. Myers is director of the Mental Hygiene Division of the Kansas State Board of Health, Topeka; Miss Gray is executive director of the Wyandotte County Guidance Center, Kansas City, Kan., and Dr. Evers is head of the Department of Education, Washburn University, Topeka.

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The report was presented in October, 1959. Photocopies can be obtained from the Children's Service of the Menninger Clinic in Topeka.

"geared" to moving and move more often than others. When moving occurs, it is toward urbanization of the family.

Family moves can significantly distort existing family adjustments. Therefore, the potential for ill effects on children, inherent in every family move, can result in more than transient emotional difficulties. Learning to predict and prevent such emotional difficulties will enable parents and other adults to help children successfully handle the serious problems that can come with mobility.

Gordon and Gordon (4) found that the incidence of emotional disorders of childhood parallels mobility. Such a comparison is not to condemn family moves, nor to say that all family moves are to some degree permanently destructive. However, such a comparison indicates that each child suffers, at least temporarily, an impairment of capacity to cope with his life situation and to make interpersonal contact. This decreased capacity, plus feelings of abandonment, loss, helplessness, isolation and fear of the unknown, may become more than temporary if the child is already anxious about his relationships with his parents, or if he interprets the move as an indication of family dysfunction, instability and possible disintegration, or if he cannot on his own, or with the help of his parents regain his former degree of capacity to cope and to make effective interpersonal contacts.

If the latter does not take place, the child's sense of helplessness can increase, and his capacity to handle his feelings on a realistic level can decrease. The trauma of the move may become more diffuse and intangible and the child's efforts at resolution may become more repetitive, ineffective and inappropriate.

The potential effect of family mobility on a child covers two areas, each of which has special characteristics and is best understood in relationship to the other. Both must be understood separately and in their interactions. The child himself, his biological and psychological forces, his basic physical and intellectual endowment, his behavior patterns and ego mechanisms which emerge in the development of his individual identity must be considered, as must also the environment and its social forces which influence the child as the maturation process takes places.

Several examples could be given of pathological responses which were precipitated by family moves. If parents could maintain or recapture the flexibility of the secure child, there would be fewer children whose maladjustment could be related to being uprooted from their former happy home and having to adjust to a new home and community. One thoughtful seven-year-old boy seemed to be preparing himself for the inevitability of change as he expressed his recognition of his parents' unhappiness since they had moved from a distant city. He confided to the therapist, with some impatience, that when he was as old as Daddy, the world would be as different for him to get used to as it was now different for Daddy from when he was a little boy.

Children of today may be able to accept change with greater equanimity than their parents. With the rapid advances in methods and speed of travel, in means of communication, time and space have new meanings which cause children to be world and space oriented. Parents whose means of livelihood has not traditionally involved transfer of residence remain neighborhood or community oriented. Unlike their children, they anticipate only the negative from a radical change of environment, yet they are forced by trends of the times to make such changes. Adjustment demands from

moving may add the degree of stress to life which is more than the parent can cope with successfully, and emotionally he becomes a less readily available parent to the child. The child suffers from the loss of the parent in the move, not from the move itself.

Parents of an eight-year-old boy sought help at a clinic because he had become so aggressive that he was almost unmanageable. In addition to being one of a gang which had broken several windows, he fought with peers, had frequent crying spells, and begged to move back to a town on the East Coast where they had always lived until a year previously.

The parents blamed themselves for having decided to move, even though the transfer meant a promotion for father. In time they saw that the boy was begging for a return to the old family relationships, not the old home town. Unconsciously, the mother was displacing onto the boy much of her resentment against the father for having decided on the move, for his long work hours in his more responsible position, and for his almost complete dedication to his work.

The father was preoccupied at home and resented the mother's apparent determination to remain aloof from forming new friendships, and her persistent recalling of the happy times in their former home town, where they had secure social positions. The tension between the parents was a new and disturbing element for the child. His temporary psychological abandonment was frightening, and he made all the motions at his command to call attention to his need.

Under similar circumstances other parents attempt to solve their adjustment to new surroundings in ways that hamper parent-child relationships and hence the maturing process of the child. Some mothers, feeling isolated, turn to one child for companionship and absorb him to the extent of excluding his peers, on the basis that he prefers her to the undesirable children in the new community. When the time comes that the school or others express concern about the child's adjustment, the parents wish to change the child, and the mother then even finds his dependency on her burdensome.

Other parents feel socially inferior to the residents of the "better" neighborhood where the family has moved because of the father's bettered financial status. Unable to identify themselves with the new group, they continue to feel rejection where it does not exist, warning their children to be similarly distrustful.

If a child identifies himself with such parents, his adjustment may become sufficiently neurotic to interfere with healthy development. He parrots his parents in talking of the unfriendly, unkind people in the new neighborhood and obtains uncomfortable satisfaction from meeting his parents' expectations of being unable to integrate himself either in the neighborhood or the new school.

In the past 10 years, an increasing number of such family situations have come to the attention of child guidance clinics. It is more important than ever before that the clinicians evaluate the sociological and cultural factors in the family history that may contribute to the family problem. Once the dynamics have been clearly described, help for both parents as well as the child is indicated, and this calls for much staff time.

When there are long waiting lists, the child often can be best served by taking the parents into therapy, even though the child must wait. His response to the change in parents' attitudes, as they begin to understand the relationships, can be quite posi-

tive. Other children in the family, even though not suffering to the extent of making themselves painful to live with, will benefit from improved family relationships.

Community clinics usually are faced with decisions as to the most valuable use of staff time in meeting service requests that far outnumber the possibility of serving. Help made available immediately to the family reacting adversely to relocation problems may be one of the most valuable uses of time in preventing the development of more serious problems.

In addition to dwelling on symptom formation and psychopathology in relation to both the external stress and conflicts which may already be internalized, we should also think about the sources of strength which enable children to tolerate family moves without lasting difficulty. The child's reaction to the sense of loss, abandonment, helplessness and fear of the unknown is the heart of the matter.

If a person were suddenly and within a split second transported by some unknown power to a native village in the heart of Africa where no outsider had ever been, it would doubtless be a shattering experience, no matter how mature and emotionally healthy the person might be. The experience might be somewhat less devastating if the individual were forced to go to the native village alone, but had time to make preparation in advance of the trip. Suppose then that our individual, who had some interest in and motivation toward visiting the same African village, had time to make extensive plans and also had the support and company on his expedition of individuals who were much more wise and experienced than he in such endeavors. His anxieties about the trip would still be present, but they might function more as protection than as shattering or disruptive influences. In any of these examples, the less emotionally healthy the individual, the more vulnerable he would be to the stresses involved.

In the first example above, the visitor to Africa would have been overwhelmed because of surprise and of complete lack of capacity to cope with the magnitude of the situation. The severe emotional responses related to family moves which certain children evidence may be compared to the first example if we bear in mind that a child at any point in his growth and development is more vulnerable than a mature and healthy adult, no matter how successfully the child has adjusted himself and emotionally matured up to any given point.

A twelve-year-old girl returned to this country with her parents after having been for six years in a foreign country where she went to an excellent American school which had a high teacher-pupil ratio. Although she had previously been an excellent student and had made a good adjutsment, when she and her family moved to a large suburban housing area and she began attending a large, overpopulated school, she immediately began to have serious academic problems as well as other difficulties with the abrupt shift in living situations. When the mother reacted strongly to the child's school and other adjustment difficulties as well as to the child's sudden puberty, the child became infantile and mute and had to be tube-fed. She had become overwhelmed by the major environmental shift and by her feeling of abandonment.

Many children participate in family moves in a way comparable to the second visitor to Africa: that is, they are told about the move in advance, but without an opportunity to feel participation and with a feeling of being forced. The only advantage that such a child has is time to work through some of his feelings in advance of the move. However, both his adjustment after the move and the working through of feelings prior to the move are unlikely if he has to do it alone and on his own.

It has been noted that one of the major

influences in preventing a child's untoward reactions to a family move is a carry-over of positive motivations about the move from the parents to the child, along with ample time and active support from the parents relative to the particular vulnerability of the child's age and level of emotional growth (8). A child afforded this kind of support compares with the third visitor in the example above.

We have not yet considered the positive forces that help to fortify a child against the anxiety inherent in family moves, forces which, if recognized and understood, might be utilized actively to help a child cope with that anxiety more efficiently and more rapidly.

The child's core problem is his relative feeling of loss, of helplessness, and of fear of the unknown in the move. However, there are certain positive, extrafamily influences which under optimum circumstances can aid the child in coping with moving.

Such circumstances would be represented by a child born into an atmosphere of acceptance, affection and approval to parents who are personally secure in a stable community in which also reside both sets of grandparents of the child, as well as numerous aunts, uncles and cousins. The father works near home at a job that he likes, does well and from which he gets adequate and satisfactory financial remuneration in comparison to his peers. The child grows physically and emotionally in an atmosphere of accepting expectant anticipation which recognizes and respects him as an individual (9).

He moves through his infancy a happy and contented individual, participating actively in the natural problems of any decisions regarding nursing, addition of solid food, sleep pattern, talking, walking, weaning and bladder and bowel control. Through the sensitivity of his parents and his own desire for gratification, and later through his desire for continued approval, each step that he takes on the developmental ladder strengthens him internally and externally by earning for him parental love and approval.

Each step that he takes strengthens the parents by increasing their security as individuals and as parents. They are strengthened externally by respect from the community and increased approval from the larger family. As the child successfully and happily moves through later infancy and preschool years with the attendant evolution of great skill development and parallel play and participant play, then the members of the larger family group and the neighborhood become more familiar, more accepted and more depended upon for acceptance and support and are used as figures for emulation and identification along with his parents.

The child moves from a secure acceptance of himself as an individual to a secure acceptance of himself as a male or female individual and embarks within the family triangle on the attempt to usurp the love and attention of the parent of the opposite sex from the parent of the same sex, a coup which will end in partial but comfortable surrender, by virtue of repression and identification with the parent of the same sex.

The circle of the child's physical world imperceptibly increases, at first with the security and support coming only from the parents and then participated in by individuals outside the immediate family. Later, much support comes from individuals outside the immediate family, with parental sanction, but without their immediate physical presence. The earliest step in a child's expanding world must be on the occasion of the first visitor who comes to see him when he arrives home from the hospital

and can only be perceived by him, perhaps, as something that is reflected to him by his mother out of her pride of motherhood.

Then follow excursions into the world of time, space and distance and involvement gradually becomes more complex and the child becomes more dependent for security and success on interacting with individuals outside his immediate family through his increasing capacities to cope independently with new situations and to relate effectively, to give and take, to love and be loved. The process starts with visits of family friends in the home and for a long time consists of tote visits and armchair and toddlers' visits outside the home to friends and relatives, including other children, but almost always in the company of the parents.

Then comes a myriad of other extra-family contacts, all of which carry a positive potential in terms of the child's security and emotional growth: babysitters, being kept for a few hours by a neighbor lady or relative, family trips, playing in the front yard beside or with the child next door (under a watchful eye), birthday parties at another child's house, with mother along, Sunday school, staying overnight with relatives, having friends in to play, playing outside in a prescribed area, nursery school, being taken to a movie, having skill development taught by someone outside the family, preschool or kindergarten, participating in activities with relatives, and many others.

By kindergarten or first grade this process of increasing world and capacity may be far enough along that the child has freedom of the immediate community and knows all the inhabitants of his immediate world by name. He may actually know some of them much better than do his parents.

As the child's dependence on immediate availability of parental support decreases and his capacity for relative independence increases, he turns to play activity with his peers, but this does not detract from the significance of adult figures outside the home who have already emerged as important in the child's emotional economy. With the beginning of school the child begins to function independently of direct contact with his parents—although it is with their permission—and the work imposed, assigned or requested by the teacher, is done to please the parents as well as the teacher.

During the grade school years children absorb and learn how to utilize factual information. Those who participate in this intellectual experience with a child must be very important parts of his life situation. Teachers and peers are probably also important to a child in helping him to maintain the relative repression of sexuality during the grade school years, since the repression contributes to the availability of the great stores of energy necessary for the intellectual job at hand. The strictly girl or boy group-play activities, and the self-structured mixed group activities which children of grade school age can allow themselves, is a function of, as well as in defense of, the repression, as are also the strong attachments often seen between two boys or two girls in this age range.

In addition to school teachers, peers and relatives, there are many other individuals outside the grade school child's immediate family who may be of great positive influence on his later capacity to handle the anxiety of such a major environmental stress as a family move. These are school principals, preachers, Sunday school teachers, significant relatives, coaches, Brownie, Cub Scout and Scout leaders, policemen, firemen, Y.M.C.A. and Y.W.C.A. activity leaders, playground directors, special skill teachers, doctors, dentists, distant hero figures, etc.

Are there unstated, but significant, prej-

udices held by school personnel toward mobile children and families? Discerning observers of schools affected by sudden and dramatic shifts of population—such as those near an expanding air force base or near an industrial development employing people from outside the community, or even the school in a city area which has had a long history of stability but which suddenly is inundated by a new class of residents, or finally, almost any school in an urban community—have had no difficulty in identifying the existence of some prejudicial attitudes.

Administrators, boards of education, teachers, and sometimes even students, on occasion, reveal hostility toward these new children. Perhaps some of these tensions evolve from the deep seated regrets of individual and group because friends have suddenly moved away. Signs of this prejudice may even be overt: open resistance to the implications of the necessary changes; reluctance to believe that the entering child could possibly be as good as the child who has left; reluctance to believe that the new student could have had the proper educational background in his previous school; excessive demands and skepticism for records from prior schools; a basic, and often openly expressed, belief that while varied experience may have some value, it remains necessarily disastrous to proper educational progress; unwillingness or inability to explain in meaningful detail to either parent or child the mores and the rules of the new school; expressed doubt that needed texts and supplies can be obtained or thinly disguised disdain for previous texts and procedures; and a real reluctance to overburden further a school budget already stripped to a substandard level.

It has often been the dream of many administrators, and many teachers too, to have a low teacher-student ratio, but even more important to have that ratio in perfect balance among every grade and among every teacher. Mobile enrollment further removes the possibility of the achievement of that dream. For the group which he conceives should have been an enduring entity, the teacher sees his well-developed plans upset and he tends to increase the group hostility toward the new child or children by suggesting that what could and would have been done together now becomes impossible.

School personnel, of course, realize the danger involved in such attitudes when self-analysis is sufficiently clear as to enable recognition, but recognition of error does not always prevent the commission of error, nor is such recognition often inclusive enough. This is particularly true when hostility arises from the destruction of a firmly held and thoroughly believed conception.

The high school age child meets many interrelated external as well as internal problems and conflicts, the resolution of which involves many individuals in addition to his parents. He must deepen, refine and increase his understanding of and capacity to utilize a vast amount of intellectual material at the same time that he must struggle toward a decision regarding his desired position in life so that the course of subjects which he takes can point in that direction.

He struggles with his desire for independence and recognition and often, in an attempt to attain them, turns to his peers for support, repudiating and ignoring the support, guidance, and superior judgment of parents, parent substitutes and authority. He must also struggle with the emergence of adult physical sexuality and the future problem of choice of a marital partner. The structure for solving these problems must provide the support and interest of and the

understanding and controls by the parents and other significant adult figures. But within the area of developing heterosexuality, much of the resolution takes place outside of the positive influence of these figures and within the members of the peer group who impinge on each other as they participate in group activities. Parents and parent figures who take the supporting roles are of unquestioned importance to these children, but from the standpoint of the child, his perception of himself and his position with the group may be of even greater significance.

Childhood is a fluid process, with shifting vulnerabilities in terms of emotional growth, emotional needs and capacity to utilize interpersonal interaction in a way to promote mental health. The personality structure of the child and the quality and the amount of parent-child interaction are important factors in determining how a child can cope with threats which are inherent in a family move. Preventive action may increase a child's strengths and decrease the chance for permanent negative response to a move. In addition to the factors just mentioned, from quite early in the child's life there are emotional health-promoting factors impinging on him from outside the immediate family.

Parents approaching a family move should be particularly aware of the relative degree of emotional maturity and stability in their child. They should be aware of the characteristic ways with which the child attempts to cope with mounting anxiety, as well as the expressions of regression which may signal a need for increased understanding and support. The parents should look carefully at their relationship with the child and search for ways to make the move which will not be destructive to that relationship but which will make the parent more available to the child prior to and following the move.

The child should not learn about the projected move from anyone other than the parents and, except for the very young child, the parents should present the decision to the child in an honest and straightforward manner. The child should know about the planned move as far in advance as possible, in order that he may work through as many of his concerns, resistances, misconceptions, and incorrect understanding as possible by participating in family dicussion, planning about the move, and feeling free to bring up questions and comments about the move.

Obviously this sort of support should be afforded the child after the move. In connection with the need-fulfilling and emotional growth-promoting forces which impinge on a child through relationships from outside the immediate family, parents about to move should understand the needs of the child for external support and the sources of those positive forces at the moment. The parents should actively consider how these positive forces can be replaced adequately and quickly following the move, and how at least some of them can be carried forward from the old life situation during the adjustment in the new.

This rough guide to the important areas of concern and possible preventive interventions relative to family moves may help parents contemplating family moves and those whom such parents may consult for advice and understanding.

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LAWRENCE M. SEIVER, M.B.A.

A layman leads a Great Books group in a mental hospital

INTRODUCTION [1]

Two years ago at the Institute of the Pennsylvania Hospital we decided to start a discussion group that would appeal to the higher level of intellect that many of our patients possess, particularly the young schizophrenics. We contacted the Great Books Foundation in the Philadelphia area for help in forming such a group. They were extremely cooperative, and we started as an experiment with a group of hand-picked patients, a resident psychiatrist, a social worker, an occupational therapist and a staff doctor, all as participants in the discussion group. The leader was the regional coordinator of Great Books. The readings we used were also chosen as experimental material in that the selections included poetry, drama, an essay, an historical document, etc., in an effort to find which type of literature evoked more response from the patients. In this area, drama *(Macbeth)* proved the most popular, since the patients, in preparation for the discussion, got together of their own accord and read the play aloud, each one taking a part.

After this first effort, we discussed with the staff and the patients whether we should train a staff member as leader or ask for a volunteer layman who had no knowledge of the patients' illnesses or any connection with psychiatry. It was decided to try the latter, and we were fortunate in finding a young business executive who was willing to lead the group. A psychiatrist and a social worker met with the group both as observers and participants. The second-year readings were used.

At the end of the year the leader wrote down his impressions of the group and how he managed the various problems that arose.

At the first Great Books discussion group I conducted at the Institute of the Pennsylvania Hospital, I learned that, based on my observation of their behavior during the discussion, I could not always accurately distinguish the patients from the staff.

Mr. Seiver is vice president of the Automobile Banking Corporation in Philadelphia. He has had many years of experience leading Great Books discussion groups and volunteered his services to the Institute of Pennsylvania Hospital.

[1] This section was written by Miss S. Sue Robinson, social worker, at the Institute of the Pennsylvania Hospital.

After this I based my own behavior as discussion leader on the assumption that I was leading a normal Great Books groups, and this plan seems to have worked out fairly well.

Most Great Books groups exhibit a predictable pattern of behavior according to the length of their participation as members of such a group. Because few people have ever participated in an adult, rational, regulated (as opposed to unregulated "bull session" or aimless) discussion, a beginning group will depend greatly on the leader.

Ideally, a leader's job is to get the discussion started and then keep it on the subject of the book being discussed. The aim is to promote an examination by the group of what the author has said, his method of saying it, and the significance of his ideas for us today. The leader asks the question; he directs the discussion but does not dominate it. There is no "material to be covered" in each session. It is not a class and there are no examinations.

During the initial sessions of any group the leader will expend a great deal of effort in "teaching" the group how to discuss along these lines. Most people are shy and must be encouraged to speak out. It takes time before one will talk without being called upon. The next development is to encourage the group to challenge each other and thereby keep the discussion moving without pushing by the leader. Of course, even from the start there will be a few eager talkers who will try to answer all the questions and talk all the time. The leader must simply squelch these few until the group itself is able to do so.

I have described the development of a typical Great Books group because I have found that the group or groups at the Institute have reacted in many ways like other groups with which I have had experience.

At the start I was faced with an almost inert group which required constant questions and prodding to provoke any talk at all. There was no cross talk, that is discussion, among the members. Everything had to pass through the leader. As individuals there were a few who responded easily and naturally to questions, some who responded reluctantly, and some who responded not at all.

I can remember being disconcerted by the unblinking stare of one woman who merely shrugged off any question addressed to her. On the other hand I was surprised when another equally immobile woman who sat, hands folded, staring at the floor, unexpectedly volunteered a comment which was quite appropriate. At the opposite extreme was at least one compulsive talker who had to be stopped regularly. On the whole, however, the first session turned out as well as I hoped it would. Afterwards, I was quite tired, a result of both my own uncertainty of what was going to happen and the constant effort needed to keep things going. Unfortunately, this first session was the first reading of the second year, *Ecclesiastes,* which is not intended for a brand-new group. Although it is not long, it is both poetic and highly emotional. These two factors in a reading tend to inhibit discussion in any group.

I realized soon that the group would not have the same people return often enough to develop the kind of discussion of which a physically and emotionally stable group might be capable. I was always losing my best participants, that is, the more "well" patients. A few patients, however, returned often enough to be considered "regulars." Like any other group, some sessions were better than others, a result of either the reading or the mood of the group. This last was possibly a manifestation of the type of individuals present at the particular session, although some of the participants

who came more or less regularly did not always react in the same way.

One young lady of high intelligence was, from the start, one of the more willing participants. She expressed herself well and obviously had not only a good educational background but also had done the reading. After a while I realized that she always avoided making positive statements. At first she would turn my questions into questions-in-return, and when later on she would answer another person's statement, it was always to contradict. Using considerable skill, she would make an interesting comment, at the end of which there would be a questioning phrase. This would have the effect of avoiding a positive assertion for the whole statement. With the questioning ending went a quizzical look; she would raise one eyebrow and half-smile. I joked with her about this habit, telling her that she would make a good leader. I became accustomed to her manner to such an extent that I was quite surprised several months later when I found her making a genuine affirmative statement.

The regularly attending nonparticipant who might make three or four irrelevant outbursts which were designed either to shock or amuse was a phenomenon to which I became accustomed. I found it best to ignore him and continue immediately with a question for another person. Having learned that these people could benefit by attending even without participating, I made no special effort to draw them into the discussion. One young man of this type never missed a meeting, never varied his behavior, and was at all times convinced that I was just another doctor.

The most striking change involved a young man whose behavior was at first not only nonco-operative but a deliberate attempt to embarrass me. At the first session he attended, he spent most of the time whispering to a young lady seated beside him. He spoke out only three or four times and each time it was an abrupt, irrelevant statement apparently designed to shock everyone by its impropriety. Each time I made no comment of my own but continued as if nothing had happened. This appeared to have some effect, because the last comment was fairly relevant and made me feel that he was quite able to participate. I was later told that he had been listening to the entire discussion carefully and was able to remember a great deal of what had taken place.

The "regulars" who actively participated became the backbone of the group. With their help we developed several sessions of real group discussion. By this I mean that the discussion moved along freely without too much prodding from the leader and with a good deal of "cross talk." The educational background and general level of intelligence of many of the patients were on a very high level. When they were inspired to discuss intelligently, the result was an excellent discussion.

Because of their obvious ability, several of the patients were of considerable personal interest to me, but I made no special effort to find out about their problems. Inevitably in talking with members of the staff I learned something about many of the patients. What I learned, however, seemed to have little relationship to the patients' behavior or comments during the discussions. One young man interested me particularly because of his tremendous erudition and enthusiasm. He could discuss the finer points of Plato's ideas with brilliance and yet with a modesty that was charming. It was incredible to me that he was completely unable to live a normal life outside of the hospital.

The usual Great Books group is in part social, but our meetings had practically

none of the usual social aspects. We usually met in a large lounge-like room in which I tried to have everyone sit in a circle. Many would, on entering, try to hide in a corner, but I could usually get them into the circle with the others. I would begin talking and questioning about the book as soon as possible with the first arrivals and continue without interruption as the other patients arrived. Many Great Books sessions are two hours with a five or ten-minute intermission. I followed this procedure at first until I realized that some of the patients, frequently the most active participants, would leave during the intermission and not return. They either found the discussion a strain or they may have been unwilling to engage in the mostly social activity which took place during the intermission. When I eliminated the break entirely, no one objected and no one who was actively participating would leave. When we did have some social activity after the discussion, I noticed a marked change in some of the patients. Although during the session they may have been relaxed and responsive, at its end they would get up and with perfectly "straight face," looking neither to right nor left, they would march out of the room.

It was not easy to predict which books would produce the best discussions. Although I did not expect it, Rousseau's *Origin of Inequality* produced one of the smoother running sessions. Several things contributed: the book itself seemed to be more stimulating of good discussion than some of the others; the group on that particular evening was composed mostly of regulars; and by this session we had met many times previously. The mood was relaxed. The group seemed very willing to participate and also willing to listen and respond to each member. This condition was most apparent when one of the patients made a sort of "intellectual" joke appropriate to the discussion. Almost everyone laughed or made a sign of understanding. Later when I was trying to determine why this session was so successful, I realized it was that this incident showed the group to be *acting* as a group, with group action and reaction.

I had some concern that the subject of insanity might cause some embarrassment and put a strain on the discussion. This might arise in discussing *Hamlet* when the question is asked whether Hamlet was possibly insane or merely acting that way. The patients seemed completely unself-conscious about the subject in general. In fact one patient made a joking reference to his own situation as a patient in a mental hospital, and most of the others laughed as they would at a pleasant family joke.

There were very few occasions when the behavior of a patient was what might be called "unexpected." Normal people have trouble enough expressing themselves clearly so that at times, although each word may be understood, the meaning itself is incomprehensible. We did have occasions when the comments did not fit the pattern of the discussion. Sometimes a patient would get tangled in the complexity of an involved sentence structure. I would never cross-examine the patient on such an occasion but would go on to someone else. Once I was disconcerted by a middle-aged male patient who began to cry in the middle of each beginning sentence. He never completed his thought and apologized profusely. Later in the same evening he was able to express himself quite well without having to stop.

I was told that many of the patients who were willing to talk during our discussions were almost completely uncommunicative and unsocial at other times. At the *Hamlet* discussion a young woman made her

only appearance of the year but spoke pleasantly and freely, and at my request answered questions asked by others of the group. Her obvious interest and knowledge of the reading made her an assest to the group. I did notice that after this discussion was over, while some of the others remained to talk with me and among themselves for a few minutes, she walked out immediately with no words or glances for anyone. When she did not return for later discussions I asked about her and found out that she was an alcoholic who was completely unsocial and uncommunicative. Narcotic addicts and alcoholics usually made excellent participants, since they were apparently able to use their normal intellectual ability when not under the influence of drugs or alcohol. Although willing talkers, they were not otherwise the most affable of patients.

One major problem is getting the patients to read and finish the readings. I found that very few patients ever finished very long (100 pages or more) selections even if they were "easy reading," such as *Gulliver's Travels*. I avoided "hard-reading" selections with one important exception. If the reading was suitable for discussion of short passages we would read a paragraph at a time and then discuss it. This worked well with Aristotle, where this is the best manner for discussion under any circumstances. Of course, readings with which many were familiar because of prior knowledge (plays and novels especially) were most popular. We avoided theology. Something about theological ideas seemed to set some of the patients off on highly personal tangents totally unrelated to the subject at hand. However, one will frequently find this sort of behavior in a so-called normal group.

The last session, devoted to *Huckleberry Finn*, turned out to be, if not the best session, certainly the gayest. Of course, it is for the most part a funny book, and talking about it seemed to put everyone in a very happy mood. We spent a great deal of time talking about the symbolism of the river. The patients eagerly participated in this part of the discussion. At this point everyone was sober and serious. One of the most active participants was a young man who admitted that he had never read the book at all, but he made up for this lack with an apparently limitless knowledge of symbolism.

When we began talking about some of the humorous incidents, what at first was gaiety became almost hilarity. This was the first and only time I ever felt that I might lose control of the group. Nevertheless, everyone seemed to be most relaxed and willing to talk and listen. The relaxed mood was probably well in keeping with the story of Huck and Jim leisurely floating down the river. We discussed the propriety of Huck's ambitionless attitude and his willingness to float along with the river. Was this the best approach to life or was he merely lazy? One patient whose problem was apparently of this nature remarked, half to himself and half to the group, that he knew how Huck felt because he sometimes felt exactly that way himself. Afterwards the resident who had been attending the discussion with us said to me, "In three therapy sessions a week for a whole year, I have never heard him admit that about himself to *me*." But then he hadn't had Mark Twain helping him.

COMMENTS [2]

Psychiatric illnesses of all types tend to produce regression in the patient. This is seen in many

[2] By J. Martin Myers, M.D., executive medical officer, Institute of the Pennsylvania Hospital, Philadelphia, Pa.

spheres of the patient's living, from the level of his attendance to biological needs, to that of social interaction. The psychiatrist in the hospital dealing with the sicker psychiatric patient is, therefore, vitally interested in offering as much as possible a type of stimulation which might hinder these regressions at whatever level they may tend to occur.

Considering the problem of intellectual stimulation, one finds a real paucity of opportunities available, particularly in a small hospital with a rather rapid turnover. When the median stay is only five or six weeks duration, any formal courses would have to be very short or one would have to resort to a type of lecture that might encourage passive listening. The experimental try with Great Books has proved a great success and a real asset in filling the intellectual void found in many inpatient activities.

The fact that each discussion centers on a different book permits the new admission to enter at any time without being at too great a disadvantage. As the leader pointed out, the discharged drop-out is somewhat frustrating, perhaps, for he may be a star discussant, but others take his place, and the real aim of the program is not primarily educational but rather medical. It should also be made clear that other than intellectual stimulation is offered by Great Books. The group interaction is a very real social stimulus. Some of the sicker patients were able to participate with others verbally for the first time by stating their interpretation of what an author was trying to say when they could not verbalize directly about their own personal feelings. In still other instances pertinent and important conflictual material appeared for the first time in the patient's individual psychotherapeutic sessions after a Great Books session which touched on these problems.

There is a very real advantage, I think, if the group leader can meet the group members with the attitude that they are the same as any so-called normal group. Certainly psychiatric orientation which might caution him to avoid certain areas might destroy his effectiveness. This was startlingly brought out at one meeting when the leader spontaneously and naturally addressed the remark "You mean you wished you were dead?" to a person not known to him to be deeply depressed and suicidal. It had none of the explosive effect that one might imagine.

The Institute of the Pennsylvania Hospital has been fortunate that Great Books sessions have been added to its general treatment program.

POVL W. TOUSSIENG, M.D.

The role of education in a residential treatment center for children

As more child guidance clinics and other psychiatric outpatient facilities are becoming available throughout the nation, residential treatment centers are dealing more and more with only those children who cannot be treated on an outpatient basis.

The reason why a child cannot be helped at home may be that he and/or his family no longer are able to cope with or to control his intense emotional conflicts or overwhelming impulses. In other cases the child is so deviant, so bizarre, or has such poor judgment that he cannot live in the community. The community may have refused outright to put up with him and his behavior, or perhaps all community resources have been tried and exhausted.

In all these cases, admission to the residential treatment center is made to meet the child's need for an around-the-clock environment which continuously can be adapted to the fluctuating levels of functioning so characteristic of severely disturbed children, and which at all times can provide support, control and protection. Such an environment usually cannot be created out in the community, especially not in a family home, but it is a prerequisite before these children can be helped through psychotherapy and other forms of treatment and often before they can benefit from education.

Many residential treatment centers have their own academic schools. These schools are set up within the residential setting because they have to serve a dual purpose:

(1) They have to support the total resi-

Dr. Toussieng is staff psychiatrist, Children's Service of The Menninger Clinic, Topeka, Kan.

This paper was presented at the Annual Conference on Exceptional Children held at Pittsburgh State Teachers College, Pittsburgh, Kan., in July, 1960.

dential treatment program, by helping to create the emotional climate needed by the child at any given time, and

(2) They have to teach the child or to help him in such a way that he can resume learning.

It is the aim of this paper to describe and discuss this dual role, a role which has a surprising number of applications to what goes on in classrooms in the community—where disturbed children also are not rare.

Most residential treatment centers will attempt as soon as possible to get newly admitted children to the point where they can attend school full time. Once this has been accomplished, the teachers spend a substantial number of hours with the children, and it becomes crucial from the standpoint of the over-all treatment effort that the experiences the children have in school are consistent with the experiences they have in the group living area, in their extracurricular activities and in formal psychotherapy, if they are receiving such treatment.

Just as the school is an integral part of the total treatment setting, the teachers are not just teachers in the school but are also members of so-called "therapeutic teams" consisting of all the people who work directly or indirectly with an individual child in the treatment setting. Corresponding to the number of children in his class, the teacher is a member of a number of teams, and he must be in close communication with the rest of the teams. In his teaching efforts he is asked primarily to identify himself with the therapeutic efforts made with a child, as well as with the therapeutic goals. We may say that the teacher is asked to be therapeutic before he tries to teach.

At a superficial glance, this places the teacher in a role for which he has no professional preparation, and which seems to make it impossible or at least very hard for him to get around to his other obligation: to provide the child with educational experiences.

In actual experience these two roles are not at all incompatible because successful education in itself can be particularly therapeutic for a disturbed child. As the child learns and finds himself learning, he acquires more tools to assess and understand the world around him. His awareness of his environment and of reality becomes sharpened; he gets help in thinking gradually on a more abstract level; he acquires more tools with which to communicate and to receive communication. Misinformation which may have threatened the child is dispelled by new knowledge.

Last, but by no means least, the educational progress in the classroom provides the disturbed child with tangible, measurable evidence of his ability to achieve, to grow, to progress, and this in itself can be an unbelievably great boost, as these children frequently have become discouraged about themselves and their abilities.

Most children who are admitted to a residential treatment center are at least one to two years retarded educationally, sometimes considerably more, even though they are of average or even very superior intellectual ability. Many of these children have been promoted socially year after year, while the gap between their performance level and that of their classmates gets wider and wider.

Even defiant, seemingly callous and poker-faced teen agers, or very disturbed psychotic youngsters with a tenuous hold on reality are on some level painfully aware of their inability to keep up with other children, although perhaps they would rather die than admit it, or although they are unable to verbalize this awareness. Feelings of failure, of worthlessness and of extreme frustration are the result. These feelings may become even more pronounced if

friendly, interested teachers make valiant and desperate efforts to teach or tutor these children and fail because the learning blocks in these children cannot be removed by educational efforts alone. Very often both at home and in the school, discipline has been tried to make the child study and learn; this leads to further blows to the child's self-respect and feelings about education as well as to many painful clashes.

By the time a child comes to a residential treatment center, schools and classrooms therefore often have become associated with painful experiences, with failure, defeat, frustration, anger and despair. As he enters the classroom in the residential treatment center, the child automatically assumes that he will have experiences similar to those he had in previous classrooms, and he will project some or all of his experiences with previous teachers on to the new teacher.

If the child, in spite of all this, is helped towards a different outcome, if he finds himself learning and able to learn, this in itself will represent a crucial corrective emotional experience, which in turn may make him more available for such other kinds of help as psychotherapy or planned group living experiences with the other children in residence.

Before the teacher can map his strategy and before he can accomplish this goal, he will have to have a thorough understanding of the factors which are preventing an individual child from making use of education and educational experiences. Such factors are always present.

Even retarded children can be expected to learn, although they learn at a slower pace and cannot progress as far as other children. If they are not learning or if they have stopped learning, there must be reasons beyond retardation which are causing this, and these reasons need to be understood. Intensive and extensive diagnostic studies need to be done as soon as possible on each child who is not learning, preferably before he is admitted to the residential setting.

These studies should include a psychiatric examination, psychological tests, a comprehensive neurological and physical work-up, often supplemented by X-rays, laboratory studies, hearing and vision examinations, brain wave tests, and so forth, but they must also establish the child's history and background, his home environment, the nature of his relationships with his parents, with siblings, with other important people in his life, with peers, with school, and so on. From these studies, from further observations and from therapeutic work with the child following admission, a deepening understanding of the child's difficulties will gradually emerge within the therapeutic team, so that more rational, comprehensive and effective plans can be made for further therapeutic intervention.

The teacher in a residential treatment center contributes many crucial observations to this diagnostic process, but he in turn must lean heavily on the observations made by the rest of the team. Sometimes the teacher has a crucial role with the child from the very start; at other times the teacher must bide his time, as it were, until the rest of the therapeutic program has helped the child improve enough that he becomes available for the teacher's efforts.

Teachers are not accustomed to working in this way and they have not been prepared for it in their training. At present, therefore, residential treatment centers have to provide on-the-job and inservice training for teachers. Other teachers obtain preliminary training by working as child care workers in a residential treatment setting before they assume teaching roles in the academic residential school.

Even with this kind of preparation, the

teacher has a difficult task, primarily because of a curious paradox. On the one hand, the teacher must show tremendous flexibility in order to meet the children's needs, and must not ask more of them than they can manage because their levels of functioning fluctuate from day to day or from moment to moment.

On the other hand, the teacher must avoid further confusing these children, who usually already are terribly confused, and he has to define the classroom setting as well as his own role as teacher very crisply, clearly, and above all, consistently. The classroom setting must be kept simple, quiet, without too much commotion. Disturbed children crumble when they have to deal with too many stimuli, particularly because so frequently they are still unable to assess and interpret adequately these stimuli.

The academic school in a residential treatment center setting is therefore the antithesis of what used to be called "a progressive school." The children do not have the initiative; the classroom structure and the dignity of the classroom are rigidly upheld. The teacher very clearly maintains his role as a mature adult and as an educator. He is ready at all times to respect the child but, on the other hand, he expects that the child will respect him and the classroom structure. As can easily be surmised, just to be able to hold himself together and not to disturb the classroom atmosphere frequently is the first and only possible goal a disturbed child has in school.

The teacher will do his utmost to bring out the child's own strengths and controls, and if these fail or prove inefficient the teacher will attempt to lend his own strength to the child. Initially, the children sometimes are unable to use the teacher's support, however, and if the child cannot hold himself together enough and if he begins to show unacceptable behavior, he will be temporarily removed from the classroom, with the very explicit understanding that this is not punishment and that he is welcome back in the classroom as soon as he thinks he can tolerate it again.

A number of children, particularly psychotic children, at times become overwhelmed by too much closeness or by their own wish for affection and closeness—which at the same time they dread. In removing a child from the classroom, the teacher respects the child's temporary need for greater distance but he will try—for example, by looking through the window, or by going outside once in awhile—to convey his continued interest in the child as well as his understanding of what is causing the child's upset just then.

The child soon will calm down and will be able to return to the classroom later the same hour or later the same day. If the child has enough strength to do so, the teacher will talk with the child about the episode and will try to understand more specifically what caused the child's upset and subsequently make plans as to how further upsets can be prevented or at least channeled.

Within this rather rigid structure the teacher also has to be tremendously flexible in order to be able at all times to adapt himself to the child's changing levels of psychological integration, as well as to his ability to stay in contact with the environment and to perform within it. It must be understood that this in no way implies permissiveness.

It is not helpful to the child—nor "therapeutic"—passively to endure his inappropriate behavior or his episodic disorganization, mainly because it keeps the child from realizing that his behavior is inappropriate, but also because it becomes impossible to perform the tasks which both the teacher

and the child expect to work on during the school hours.

If the classroom is allowed to become chaotic, this will increase a child's panic and internal chaos and will only make matters worse. On the other hand, the teacher must be able to simplify or temporarily abandon the educational tasks whenever a child is on a more infantile level or becomes totally disorganized, without feeling that he, the teacher, and/or the child failed, and without resentment. If the teacher does feel disappointment—even though he tries not to show it—the uncannily sensitive psychotic or very disturbed child will invariably know it and he will become even more discouraged about his own abilities.

It is not easy for a teacher to get used to this, nor is it always easy to understand that the child's—particularly a teen ager's—behavior does not represent naughtiness, manipulation, or any other willful act, but a temporary breakdown in personality organization. The teacher is helped in this task by the fact that emotionally disturbed children, when given the support and protection of a residential setting, almost invariably show a strong wish to make use of education, even though they do not yet have the strength to act continuously on the basis of this wish.

In dealing immediately with the inappropriate behavior, the teacher allies himself with this wish and he appeals to the remaining strengths in the child. In essence, when he removes the child from the classroom, the teacher implicitly or even explicitly says to the child that he knows that the child has strength, and that he trusts that the child sooner or later will be able again to use this strength and to control himself enough to take his place in the classroom again. When this happens both the child and the teacher see it as an accomplishment, as a small but important victory, as another evidence of the child's growing strength.

As these and similar considerations stand out in the teacher's task, it will be understood more easily why giving the children tools and helping them acquire knowledge are equally important goals to teachers in residential treatment centers. The primary emphasis is on removing the blocks which are preventing the children from learning, as well as on opening up avenues along which the children can learn if they are unable to learn through conventional methods. This amounts to preparation for later learning.

The gratifying fact is that the great majority of children eventually can be helped to learn. Not at all infrequently they then catch up with themselves and make up for the time they got behind in school, as well as for the time it took to help them to become able to learn again. This preparation for later learning is accomplished by giving the children strictly educational tasks and not by trying to play with them in hidden or more overt ways.

Reading, writing and arithmetic are the usual tasks given. These assignments, of course, have to be adapted to the child's level of functioning. The teaching method used takes into consideration the child's abilities, the rate at which he is able to learn, his degree of distractibility, the length of his attention span, his difficulties in perception, his possible need for motoric outlets, etc.

In this respect an adequate initial diagnostic work-up will be of crucial importance to the teacher, as it helps define exactly what a child's strengths and handicaps are and what it will take to help him to get to the point where he can resume learning. It does make a difference whether a child has extreme difficulties in keeping his thoughts organized, whether he is constantly fighting

off confusion, or whether he, for example, is suffering from some degree of aphasia, which makes it impossible for him to learn by conventional methods.

Sometimes several difficulties are present simultaneously; it then needs to be established which difficulties are most prominent just then, and the educational tasks have to be presented accordingly. One ten-year-old girl came into a residential treatment center with a severe psychotic adjustment, even though it also was suspected that she was retarded and brain-damaged. Previous painful school experiences made it necessary first to give the child a corrective experience with the teacher.

Much work involving rote memory was used to help her organize her thoughts and herself, while the same problem also was being dealt with in psychotherapy. Even so, the child continued to have great difficulty with her educational tasks. As she gradually improved and gained more psychological strength, it stood out that she still could not learn to read and could not be helped to retain word pictures. Some aphasic difficulty was suspected, particularly because of her extreme difficulty in abstract thinking.

Intensive tutoring was started, using a kinesthetic method for the analysis of words. The child responded dramatically to this and made remarkable strides in her academic achievement. While she had struggled slowly and laboriously through the third and fourth grades, she whisked through the fifth and sixth in 10 months.

Her newly acquired ability to read, to accomplish something academically, has been a tremendous boost to this child's morale and has helped her gain strength in other areas, particularly in the area of interpersonal relationships where before she had overwhelming difficulties. In the book *The Brain Injured Child* [1] Strauss and Lehtinen describe similar dramatic effects of remedial tutoring.

Many aphasic children can be helped by these methods to return to regular classrooms for some subjects, maybe even full time. It must be stressed, however, that even a sensitive method of tutoring is useless until a corrective emotional experience has mobilized a disturbed child's strength and makes it possible for him to do what he could not do before, or at least to try.

The following excerpt from the latest educational report on the ten-year-old girl mentioned above—who is now fourteen—will illustrate this in more detail:

"Mary is much more comfortable and exhibits less tension than before in working at her school assignments. She seems not so fearful of the exposure of her inadequacies and does not feel the inevitability of failure. This is particularly true of her reading performance and has resulted in more efficient work as well as changes in her voice and expression.

"It is the teacher's opinion that the fact that she has made gains in reading, and that she has profited from the reading technique employed, has been a major factor in the progress seen in all of her school work. The experience of success and the gaining of confidence has carried over into the rest of the learning areas, giving impetus to her performance in all subjects. She seems to feel gratification from her progress and to be seeking less for the 'magic way' of learning and overcoming deficiencies—which she showed when she came to the school.

"She still is often preoccupied with 'catching up', obsessed with problems of how much there is to do and how long it will take her to catch up to her chronological age level in school; although there is evidence of feelings of depression and futility around this, she more and more is evidencing a realistic view of her limitations and levels without the need to feel that there is a 'formula' to overcome these.

"It may be noted that Mary displays a great

[1] Strauss, A. A. and L. E. Lehtinen, *The Brain Injured Child* (New York: Grune & Stratton, Inc., 1947).

need for 'sameness' and consistency in the environment. She becomes confused and disturbed when things and events are not in their 'place.' She usually is unable to tolerate changes in the physical environment or in routine without 'worrying' about them, or until they become more familiar to her. She is often preoccupied and disturbed with details in the environment or with what she feels to be discrepancies or contradictions. It is felt that she displays an excessive reliance on organization from the 'outside' as a result of her limitations in achieving an internal organization and an understanding of environmental relationships.

"With the reading technique being utilized—an auditory-visual-kinesthetic approach which uses rules and drill to overcome limitations of perceptual and conceptual organization—she has made measurable gains. She displays good retention of the 'base' words of consonants and vowels and has mastered the sounds presented. She is able to read much faster and is better able to 'sound out' words.

"She can go through the whole pack of drill cards with few mistakes and usually will read in phrases instead of reading a word at a time as she had previously done. Reversals of letters have largely disappeared in both reading and writing. She has done well on the syllable division rules and on the spelling rules presented, although these have not yet been committed to memory.

"She is very low in spelling and much repetitive drill seems indicated. It is characteristic for her to spend long, hard effort on all the tasks given her and it is felt that the concrete approach of this technique makes it a helpful and profitable one for her."

Another example is provided by Max, age fifteen, who was admitted to the Kansas Industrial School for Boys because of his stealing and other delinquent activities.

"The patient obtained a median of 8.8 on a Stanford Achievement Test given on admission. The schools he had attended had been unable to cope with him. He frequently fought in school and played truant. The initial intensive work-up, done on all boys recently admitted to the Industrial School, revealed that Max was seriously emotionally disturbed and that his hold on reality was inconsistent and tenuous.

"Intense efforts were made in the group living situation, but also through group psychotherapy, to gradually help Max get himself under better control. During this period he was unable to do any work in the academic school, and the teachers at first merely concentrated on making it possible for him stay in the classroom without having to be sent back to the cottage for defiant behavior.

"As Max's anxiety gradually diminished, and as he gained greater control over himself, he began to be able to respond to direct educational efforts. When he was paroled from the Industrial School, after a stay of 15 months, he achieved a median of 12.7 on the Stanford Achievement Test. At home he entered the eleventh grade, and did extremely well in high school."

Still another example is the case of a ten-year-old adopted boy who has intense conflicts about the meanings of growing up. As so often happens, his parents had several natural children after the adoption of this child. The boy has had a very strong emotional reaction to this, fearing that any evidence of growing independence on his part will give the parents an excuse to send him away forever.

These struggles and fears were carried over into the school, gradually resulting in more and more destructive classroom behavior and in the development of a complete learning block. The situation at home as well as in the school gradually became so impossible that the parents had to admit him to a residential treatment center.

Here it was found that he still could not read and that he had picked up very little of the elementary school subjects, in spite of the fact that he was of high-average or possibly even bright-normal intelligence. There is some evidence in the tests that organic brain functioning may be mildly impaired. The work which the teachers have done with this boy so far is described in the following educational report:

"During the second half of the school year,

John has made advances in school which suggest significant shifts in his adjustment and his capacity to perform in a learning situation. This has not been in the accomplishment of learning tasks or in the attaining of direct academic goals, but it has been in the beginning of a different concept of school and in a new adjustment which is essential to the establishment of an educational process.

"Work with John has been aimed at what might be termed pre-educational goals. He is not as yet ready to profit in a major way from the educational tasks and guidance which are offered to others of John's age level because the difficulties of adjustment and performance—both psychological and organic—which resulted in his original failures in school have become intertwined with his reaction to the long history of inadequacy, rejection and guilt regarding his past failures in school.

"He views school as a frightening, hostile, anxiety-provoking situation, where he can only have his inadequacies exposed and be subjected to humiliation, rejection and retaliation. The emphasis of the school work with John has been on the formation of a comfortable teacher-pupil relationship, which may be utilized to alter his adjustment and to permit education to be accomplished.

"It is in the area of the formation of such a relationship that the greatest advances may be reported, although it must be stressed that this still is in the beginning and tenuous phase. As the relationship with various teachers is being established, inroads have been made through these relationships into his feelings of inadequacy, worthlessness and unacceptability. As this has occurred, it has been possible for the teachers to place increasingly more demands on him for work, for his participation in tasks, and to gain his involvement in this.

"Particularly firm stress has been placed on the expectation that he will pay attention, with satisfactory results as his ability to make use of instruction increases. He still relies excessively on the structure which the teacher poses, having little capacity to organize his tasks and his time, and he functions best when the teacher is near to him or touches him. In almost all his school work, he and his teacher perform tasks together.

"It must be noted that he is still limited in the amount of time he can spend at his work, or even in the amount of time he can pay attention and involve himself with the teacher. His work and attention span is often no longer than 10 minutes, and he frequently does not appear to be directly attentive to the teacher, regardless of what they are doing together. It seems that he is able to mobilize the strength and energy to accomplish school work only in order to please the teacher and to avoid the punishment he seems to feel would follow if he did not make an attempt.

"John has begun work with phonics and has completed the beginning workbook in this subject. He has shown some gains in identifying the beginning sounds of words, but he is unable consistently to connect sounds with letters. Although he can look at words and identify each letter, he is unable to associate the sound with the letter, even in his own name. However, he has shown a surprising ability to connect words with objects in multiple-choice exercises with enough consistency to warrant the speculation that he has begun to develop in reading and that reading-readiness tasks are profitable at this time. In arithmetic he has continued in tasks which give him experiences with concrete objects in order to allow him to arrive at his own abstractions and memorize combinations at his own pace.

"In preparing plans for John for the next year, it is necessary to continue to view the main objectives of the school as pre-educational, with the estimate that it may be some time before he will be able to learn with normal skill and ease. Although the teacher's goal will be to explore, assess and prepare him to make greater use of learning experiences, his work will center around actual educational tasks as a necessary and expedient way to form the correct teacher-pupil relationship, to provide a therapeutic school situation which may mend his earlier concepts and conflicts, and to begin an educational process.

"He will continue to have individual sessions with the reading teacher to strengthen and capitalize on the relationship he has formed with her, and because of this probability, based on the symptomatic picture, he will need specialized help in this area."

The conclusion offering itself from this discussion is that the teacher's role in a residential treatment center is surprisingly sim-

ilar to the role of a teacher in a community classroom, even though there also are significant differences.

It is evident that the teacher's contribution in a residential treatment setting can be very therapeutic for a child but that teacher, isolated from the total treatment setting, cannot be therapeutic. In order to be of help to the child, the teacher must maintain his role and identity as an educator and he therefore cannot and must not try to become the child's therapist.

While upholding the dignity and importance of the classroom, the teacher continuously can draw upon the deepening and extensive understanding of the child's difficulties, which gradually emerges as the teacher and all the other staff members working with the child pool their observations and experiences in a continued diagnostic process. On the basis of this understanding and on the building of the child's other therapeutic experiences in the residential treatment setting, the teacher can employ strictly educational tasks to first prepare the child for learning and later to help him to learn—up to the limits of his native endowment.

The therapeutic value of this well-defined educational approach may well have implications for how far teachers in the community should allow themselves—in the most literal sense—to be deflected from their teaching role.

F. LESLIE KAMMERDIENER, JR., B.S., B.D., TH.M., M.A.

Fundamental facts relating to the counseling and higher education of epileptic persons

Although epilepsy "is more common than polio, active tuberculosis, or asthma among children," it still "remains in the realm of superstition, fear, and ignorance" neglected in major research.[1]

There is often a lack of understanding on the part of the average teacher and school administrator and sometimes the incident of a grand mal seizure in the classroom is reported "to the principal as though it had been a discipline problem."[2] The average teacher will have to deal with a half-dozen or so epileptic children during his teaching career, and he therefore owes it to the students involved to know something of this disease.

Epilepsy itself is not a disease but it is the symptom of an underlying disorder which sometimes may be corrected, and in many other cases the seizure symptoms at least can be controlled.[3] "Causal factors of epilepsy may be classified as basically organic or idiopathic in nature."[4] Collins uses the terms "traumatic" and "essential," but she refers to the same two basic classifications, using a term of more limited scope for whole categories.[5]

Organic factors include such things as trauma, birth injury, endocrinopathy, congenital defects, encephalitism and brain tumor. Idiopathic or essential factors are those in which nothing other than a con-

Mr. Kammerdiener is an instructor in psychology at Wayland Baptist College, Plainview, Tex.

[1] Easley, Glenn, "Does Your School Say—Epileptics Not Wanted," *The Texas Outlook*, 37(May, 1953), 12.

[2] *Ibid.*

[3] *Ibid.*

[4] Himler, Leonard E. and Theophile Raphael, "Epilepsy Among College Students," *Mental Hygiene*, 24(July, 1940), 459-68.

[5] Collins, A. Louise, "Epileptic Intelligence," *Journal of Consulting Psychology*, 15(October, 1951), 395.

stitutional predisposition could be put forward as being of etiologic significance.

Epilepsy is evidenced outwardly in three basic responses or symptoms: "Petit mal" (transient lapse of consciousness without muscular symptoms), "Grand mal" (convulsions), and "Psychomotor seizures" (periods of amnesia or automatism).[6]

While admittedly narrow in scope, a study, made by Himler and Raphael of University of Michigan students whose epileptic condition came to the attention of the school authorities, indicates that certain precipitating factors were associated significantly with individual attacks.[7] Fatigue, irregular habits, overindulgence in alcohol, and special situational stresses, academic and otherwise, are very prominent in the study of these factors. Insufficient co-operation or irregularity in carrying out prescribed medical routine also figured prominently in unimproved cases.

> "—the therapy of epilepsy in college being not unlike extramural practice in this respect." [8]

Overinhalation such as that caused by hard play or exercise[9] and photic stimulation also have been found to precipitate the brain wave pattern associated with epileptic seizures.

Some patients have warning of an approaching seizure, but most do not.[10] Such factors as irritability, slight confusion, abnormal sensitivity, and the feeling of illease may be indicators of oncoming seizures. At the time of an attack there is nothing that can be done except to prevent the patient from hurting himself through falling or biting his tongue. Treatment formerly involved the use of bromides and phenobarbital, dietary regulation and fluid restriction.[11] Because the sedation which occurred with these therapeutic procedures interfered with attentiveness in classes and evening study periods, newer nonsedative, anticonvulsant drugs (diphenylhydantoin derivatives) have come to the forefront. While reducing the number of seizures they do not promise "complete relief." [12] Speaking of the miracle drugs, Easley says:

> "All of these drugs tend to sedate the patient to some extent, but many patients live normal lives taking some of these drugs every day and they suffer no mental deterioration and no noticeable physical damage." [13]

Collins[14] has completed a monumental study of epileptic intelligence, and the results differ materially from previous investigations. Basically this is due to the difference in type of patient-group under investigation. As is pointed out in this study,[15] past studies of epileptic intelligence have been based largely upon the records of institutionalized or public clinic patients and often included a large proportion of mental defectives. Specifically:

> "The intellectual defects were usually concomitants or precedent conditions and no resultants of the epilepsy, but the low intelligence found was often assumed to be that of epileptics in general." [16]

In these studies:

> "Normal-living private patients, who form the great majority of the country's epileptic popu-

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[6] Lennox, William G., Merle McBride and Gertrude Potter, "The Higher Education of Epileptics," *Journal of Health and Physical Education*, 19(November, 1948), 626.

[7] Himler and Raphael, *op. cit.*, 464.

[8] *Ibid.*, 466.

[9] Easley, *op. cit.*, 13, 40.

[10] *Ibid.*, 13.

[11] Himler & Raphael, *op. cit.*, 466.

[12] Easley, *op. cit.*, 40.

[13] *Ibid.*

[14] Collins, *op. cit.*

[15] *Ibid*, 392.

[16] *Ibid.*

lation, conservatively estimated at a half million, were not sampled." [17]

The Collins study is based on the private patients of Dr. William G. Lennox, neurologist and recognized authority in the field of epilepsy. These patients were treated at the Seizure Unit of the Children's Medical Center in Boston and represent both referral and voluntary non-referral type patients. Some 400 adult and adolescent epileptic, extramural office patients were studied by means of the Wechsler-Bellevue intelligence tests. Clerical, business, and professional classes composed the majority of occupational types, and the large majority of these persons ranked well above average in this status.[18]

The age of the patients involved in this study ranged from thirteen to sixty-three, with an average age of 24.8 years. The educational level was naturally high, higher than the national norm in fact, because of the selective nature of the patient group with regard to age, occupational and financial status. More than one-half of the group had attained the high school level, and more than one-fourth had reached the college, professional, or graduate school level.[19]

While early onset and long duration have long been considered as detrimental, this new study reveals that:

"—the effect of early onset would appear to be decidedly detrimental, and the effect of long duration far less so." [20]

When interpreting this statement, however, it is noted that the effect of the onset age concerns

"—only present psychometric results, not original endowment, and implies nothing as to whether the cause of the suggested deficit is an organic effect of the disorder that retards normal development, or whether it is a social and environmental effect." [21]

In this specific study, the IQ's of epileptic patients varied according to the type of seizure involved. Those whose seizures were wholly or in part petit mal rank highest in IQ; psychomotor cases next and the grand mal subjects slightly lower.[22] The differences were not great, however, and all three groups in this study ranked above the population norm.[23]

Significant in these findings is the fact that the grand mal subjects probably had more interference with normal social and educational opportunity because of the severity of the seizure state than the two other groups, and hence might not actually rank as they did if the seizure state did not affect these opportunities quite as much.

In the analysis of the IQ of the various subjects in the Collins study (according to the type of epilepsy, that is organic or idiopathic), another error in past observation was encountered. Formerly it was thought that the idiopathic type of epilepsy had a more deteriorating effect on the patient's mentality than did the organic or brain injury type. The results of the IQ subscore tests, however, definitely contradict this early belief, "for the essential subjects average more than 12 IQ points above the traumatic." [24] Although a few of the individuals tested showed definite deterioration, this was not found to be a "group characteristic." [25] Generally the superiority

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17 *Ibid.*

18 *Ibid.*

19 *Ibid*, 394.

20 *Ibid.*

21 *Ibid.*

22 *Ibid.*

23 *Ibid.*

24 Collins, *op. cit.*, 395.

25 *Ibid*, 397.

in thinking, reasoning power, and concept formation found in the Collins study:

> "—may be due to the superior intelligence and education of the group."

but low ratings in digit span—implying anxiety—and consistently high ratings in comprehension of all the groups under study may . . . "justifiably be considered as an epileptic characteristic." [26]

In concluding the report of the Collins study it is noted that there was no conformity with observed patterns of psychotics or psychopaths, and little similarity to the patterns of neurotics.[27] Environmental causes preventing normal social contacts and educational opportunities are here considered . . . "potent factors in causing the apparent deterioration, formerly considered inevitable." [28] Even the drug effects of the older types of therapy may be considered among these factors. Thus, mental defect or low intelligence is not to be assumed to result from, or necessarily to accompany, epilepsy.

It should be pointed out at this point that the handicap of epilepsy, based as it is on unreasoned fear of a convulsion, and on misinformation concerning the intelligence and personality of the noninstitutionalized epileptic, is "more social than physical." [29] The basic therapeutic approach, therefore, as is pointed out by Patry,[30] must:

> "—be directed toward a constructive reintegration of the total personality, which includes competent management of the psycho-affective aspect as well as the specific clinical features related to the attacks as such."

At the University of Michigan, Himler points out that the

> "—situational and personality problems presented by the epileptic students do not differ widely from those found in the general run of college students seen by the mental hygiene unit." [31]

Such factors as egocentricity, instability, overimpulsiveness, lack of regularity, and poor self-discipline, although weighing heavier as a whole, are typical not only of the epileptic students who came to the clinic but also of the student body, as a whole, who needed help from the clinic.

Unsatisfactory academic achievement, perhaps caused to a large extent by frequent feelings of inferiority and pessimism over the handicap, demanded consideration in the counseling of students. Here the student must come to understand his difficulty in "factual, nonalarmist terms" and develop a positive confidence in the future and a wholesome philosophy of life before satisfactory academic and occupational success may be achieved. On the above campus, actual treatment was not nearly so successful in terms of reducing the number and frequency of attacks occurring as was the treatment of the personality problems involved.[32]

In a study of the social problems associated with epilepsy, Elabel Davidson and Joan Thomas used both the volunteer interview system and specific casework service over a period of months—and in one case three years—to determine the needs, capabilities and acceptance of epileptic persons in the Montreal, Canada, area.[33]

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[26] *Ibid.*

[27] *Ibid.*

[28] *Ibid.*, 598.

[29] Lennox, *op. cit.*, 626.

[30] *See* Patry, F. L., "Psychiatric Principles in Educational Methodology with Special Reference to Epileptics," *Medical Times*, 67(August, 1939), 369–71, as noted in Himler, *op. cit.*, 464.

[31] Himler, *op. cit.*, 464.

[32] *Ibid.*

[33] Davidson, Elabel Mcl. and Joan C. Thomas, "A Social Study of Epileptic Patients," *Journal of Social Casework*, 30(November, 1949), 380–84.

It is interesting to note here that areas of mobile population and less societal eliteness are far less prone to offer limitations of opportunity and to exhibit social rejection and discrimination than are areas where societal conditions are quite elite and the population extremely stable. In the Canadian study, one common factor for all persons under study was the low or moderate income factor.[34] Also, the education level was low, which might have correlated because of the financial level. In interpreting the social problems of this group of people, three main factors contributed to the handicap of the individuals: the physical condition itself (type, frequency, severity, age of onset, etc.), the individual personality or total emotional make-up of the patient, and the broader environmental factors.

Actual personal and social adjustment was found to vary independently of the seizure picture and the latter two factors were found to be of more significance for the group as a whole than was the first.[35]

In contrast to the study of Collins, which was significantly limited to the intelligence factor of epileptic patients, this study dealt primarily with four main areas of life experience: parental relationships, schooling, employment, and interpersonal relationships.[36]

Of basic importance was the discovery that the insecurity and fearfulness of parents, exhibited in feelings of shame and disgrace, was vitally related to the personality development and desire for parenthood on the part of the epileptic. Overprotection and dominance became evident, especially among the mothers of the group.

In this Montreal study, the anxiety and tension of concealment which sometimes permitted the continuance of formal education among the group under study often led to severe psychological shock at the termination of this formal learning situation. As is generally the case with any group isolated or segregated because of a handicap, this study emphasized the "inability to meet any unprotected situation" and the prevention of full "development of potentialities" on the part of the isolated.[37]

In the area of employment the Canadian study determined that a waste of manpower and a psychological toll result when persons are denied work or are discriminated against in other ways in "nonaffected" types of work. Actually, employment hinged largely on "understanding employers" and the resistance to epileptic employment in these nonaffected types of work was based mainly "on emotional prejudice rather than on realistic concern for their safety and that of others."[38]

One recommendation from this study was that persons with problem seizures that could not be adequately controlled, or at least materially reduced, should be provided with "rehabilitation centers and sheltered workshops" for the sake of themselves and for the sake of those epileptics whose seizures are now adequately controlled.[39]

When investigating the resultant effects on interpersonal relationships, it is interesting to note that those patients whose seizures started after marriage did not usually experience the traumatic experiences of the unmarried. It is also to be noted that any decision concerning mar-

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[34] *Ibid.*, 380.

[35] *Ibid*, p. 381.

[36] *Ibid.*

[37] *Ibid*, 382.

[38] *Ibid.*

[39] *Ibid.*, 383.

riage should be made on a "personal and individual basis" and not on "blanket exclusion because of diagnosis." [40]

While formerly it was considered essential to keep epileptics quiet and undisturbed at all times, it is now clear that physical and mental activity—within reasonable limits—reduces the likelihood of an attack.[41] This, however, is an area that needs to be brought to the attention of the patient by means of counseling, because not all patients are willing to accept and apply this, even when they know it to be generally considered true by the medical profession.

Social isolation, additional sensitivity, feelings of differences and anxiety have resulted in the failure of many persons with epilepsy to marry. Antiquated laws requiring sterilization before marriage in some states, the refusal to grant drivers licenses (to those adequately controlled) in other states, etc., are factors which even yet mitigate against the healthy social and economic development of the individual.

In coming to the proper understanding of the relationship of epilepsy to education, physical health and parental attitudes, Lampe [42] lists some seven particular sources of information which are of value here.

To be noted is the work of Lennox [43] and Collins,[44] both of whom have studied the intellectual capacity of epileptics. Tenny's work in the area of psychosocial behavior is also of great importance.[45] The medical aspects of epilepsy are treated in the writings of Harriet Randall [46] and particular educational problems are investigated in the Ohio Study.[47] For the parent and interested lay person, various pamphlets available from the Epilepsy League.[48] Additional material from the federal government [49] also should be of interest.

In relating the college situation to other social relations, Hemler [50] says:

> "—it is essential that it be realized that the element of stigma traditionally attached to epilepsy has no place in any modern valid conception of the disorder. In other words, the convulsive state must be envisaged simply as one medical condition, among many others, to be appraised upon its clinical merits, broadly conceived—"

Because all higher education must be prefaced by previous study it is important to note various attitudes, particularly in public school education. Lampe [51] feels that school authorities and teachers should be fully aware of the epileptic child's situation ahead of time. This, in order that proper safeguards, preplanning and guidance, and an adequate understanding of seizure patterns may be accomplished before stigmatization and other consequences

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[40] *Ibid.*

[41] *Ibid.*

[42] Lampe, John M., "Education and Epilepsy," *The Journal of School Health*, 29(June, 1959), 220–23. (Dr. Lampe is asociated with the Health Service Department of the Denver, Colo., public schools.)

[43] Lennox, W. G., *Science and Seizures* (New York: Harper & Bros., 1946).

[44] *Op. cit.*

[45] Tenny, John, "Epileptic Children in Detroit Special School Program," *Journal of Exceptional Children*, 21(February, 1955), 162–67.

[46] Randall, Harriet B., *Medical Woman's Journal*, 57(December, 1950), 12, 22.

[47] Frampton, Merle E. and E. D. Gall, eds., "Ohio State Study" in *Special Education for the Exceptional* (Boston: Porter Sargent, 1956).

[48] Gibbs, F. A., *A Modern View of Epilepsy* (Chicago: National Epilepsy League, 1948).

[49] U. S. Children's Bureau, *The Child with Epilepsy* (Washington, D. C.: Government Printing Office, 1952), Children's Bureau Folder No. 35.

[50] Himler, *op. cit.*, 468.

[51] *Op. cit.*, 220.

of failing to have this information may arise.

Lampe [52] feels that the child's associates in school may be more easily interested and made aware of the needs and capabilities of the epileptic child than can adults who have preconceived ideas and erroneous notions about epileptics in general.

In discussing the two basic approaches to the education of the children involved, Lampe [53] discusses homogeneous and heterogeneous groupings. Basically heterogeneous groupings will provide opportunities and responsibilities comparable to those that the child will face all of his life. Yet, because the majority as well as the minority have rights, he feels that some homogeneous groupings may be necessary.[54] Extremely frequent seizures, demanding a disproportionate amount of teacher time, continued ill effects on other students, etc., may, he feels, occasionally demand home teaching and complete exclusion from public school life.

In discussing other obvious restrictions in school life,[55] he seems to have forgotten that all cases do not demand "routinely imposed exclusion" even if it is for but "one year beyond the date of the last seizure." [56] Obviously a case history of nocturnal seizures does not demand the same restriction as does a case history of seizure at unpredictable hours of the day and night.

Having passed on to another problem area, that of employing epileptic personnel, he points to obvious limitations on bus driving and to such board decision areas as teaching in the system at all.[57]

After briefly mentioning such factors as the effects of teacher seizure on pupils, supposed "legal and moral implications of *unpredictable* incapacity of a responsible person in a public institution," [58] he touches even more briefly on the trauma experienced by the individual seeking employment after preparation and expectation of being employed, and the loss of "capable trained individuals to an undermanned profession." [59] Giving no analysis or interpretation to the above problems he simply and curtly states that in Denver it has not been the policy to accept teachers having a record of epilepsy.[60]

Noted in Himler's and Raphael's study of college students are certain basic facts relating to the epileptic student and higher education. In this study it was found that roughly two out of every five epileptic students developed this condition while in residence.[61]

The actual incidence of epileptic disorder (.06 per cent) [62] among the student population was identical with the figure Patry [63] found among New York public school children. This actually is a minimum figure for the college group because of unreported or unrecognized cases (particularly nocturnal seizures) and effective preventive measures by outside physicians.[64]

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[52] *Op. cit.*, 220–21.

[53] *Ibid.*

[54] *Ibid.*

[55] *Ibid*, 222 (swimming, rope climbing, entertainment, athletics etc.)

[56] *Ibid.*

[57] *Ibid.*

[58] *Ibid.*

[59] *Ibid.*

[60] *Ibid.*

[61] Himler, *op. cit.*, 459.

[62] *Ibid.*

[63] Patry, F. L., "The Epileptic School Child," *New York State Journal of Medicine*, 37(September 15, 1937), 1553–58, as quoted by Himler, *ibid.*, 460.

[64] *Ibid.*, 460.

Himler [65] cites Lennox's estimate that 0.5 per cent, or approximately 5 per 1,000 persons, of the adult population at large have epilepsy.

In a study by Lennox, McBride and Potter [66] the figures on actual density of epileptics per 1,000 students show some 0.48 per 1,000 were registered, the number varying from 0.91 in schools of 300 or less enrollment to 0.38 in those with an enrollment of 1,500 or more.

It is estimated that in the United States in 1950 some 2,659,021 persons were enrolled in schools of higher education,[67] while the total estimated population was 154,233,234.[68] Thus, some 1.72 per cent of the U. S. population was engaged in higher education in 1950.

If one takes the estimated total U. S. epileptic population of some 0.5 per cent or 771,166.1 persons, and the total estimated epileptic persons enrolled in higher education, some .06 per cent of 2,659,021 persons, or 1,595.4, it is found that only .2 per cent of the estimated epileptic population is enrolled as compared to some 1.72 per cent of total population enrolled. Thus, all other factors being equal (i.e., age, proper school, financial background, etc.) one would have some eight and one-half times better chance to go into higher education if not epileptic than *if* epileptic. This fact is pointed out by Lennox [69] when he says "hindrances to climbing the educational ladder increase with its height."

In the study by Himler and Raphael it is pointed out that not only does it become more difficult for the epileptic to obtain a higher education but the adjustment problems are definitely more trying and the frequency of attacks quite likely to increase.[70]

This does not mean, however, that epileptic students cannot do satisfactory college or university work in selected instances and under adequate care and management.[71]

In relating the total number of epileptic to psychotic students enrolled each year during the period of study, Himler found that the totals were quite similar. There were more new cases of psychoses each year, however, indicating that often the student with epilepsy could remain in training, while those with psychoses had to be dismissed.[72] In the Lennox study of 1948 this ability to remain in school is backed by the statement that—

> "Given a degree of tolerance and of co-operation on the part of the administration and fellow students, the majority of epileptic students of college age who are receiving treatment should, on purely medical grounds, be acceptable." [73]

In the concluding portion of this paper an attempt will be made to analyze and interpret the statistical information concerning the incidence of epilepsy as related to school size, admission policy, levels of achievement, special services provided, effect of seizures on the individual, total program and problems faced by both school and student in the provision and securing

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[65] *Ibid.*, 460. See Lennox, W. G., E. C. Gibbs and F. A. Gibbs, "Inheritance of Epilepsy as Revealed by the Electroencephalogram," *Journal of the American Medical Association*, 113(September 9, 1939), 1002–05.

[66] *Op. cit.*, 597–98.

[67] U. S. Department of Commerce, *Statistical Abstract of the United States, 80th Annual Edition* (Washington, D. C.: Government Printing Office, 1959), 122, Table 156.

[68] *Ibid.*, 8, Table 4.

[69] Lennox, "The Higher Education of Epileptics," *op. cit.*

[70] *Op. cit.*, 466.

[71] *Ibid.*, 466–67.

[72] *Ibid.*, 461.

[73] Lennox, "The Higher Education of Epileptics," *op. cit.*

of a higher education. The work of Willard Abraham[74] and of Lennox *et al.*,[75] will be the basis for this discussion.

In the Lennox survey published in 1948, 1,676 schools in the United States were sent self-addressed, stamped envelopes by the American Epilepsy League. Of these, 79 per cent, or 1,331, replied: those failing to reply were usually "those with small enrollments."[76] The total enrollment of those replying amounted to some 950,000 of the approximately one-million total U. S. college and university enrollment in 1946.[77] Generally, greater reluctance to epileptic enrollment was found in the smaller schools.[78] Possibly this reflects the fact that many larger schools have full-time medical staffs, where smaller schools do not.

The admission policy, as revealed in this study, showed 44 per cent of the schools to have no rule; 21 per cent admitted epileptics conditionally; 14 per cent refused admission; and 21 per cent did not return the questionnaire. Types of schools varied in their acceptance policy.[79] In military schools, none accepted; theology, 6 per cent; art and music, 12 per cent; and schools of arts and sciences, 28 per cent. It is interesting to note that such military leaders as Julius Caesar, Alexander the Great, and possibly Napoleon would be unacceptable candidates today. Also, Canon 984 of the Roman Catholic Church forbids priesthood to any and all past and present epileptics.[80]

Because more small colleges, theological, normal and technical schools are located in the eastern states, this explains, in part at least, the higher percentage (26 per cent) of eastern schools over other sections absolutely rejecting epileptic enrollment.

The actual picture of epileptic enrollment has been clouded by several factors. Seizures beginning after enrollment, scholastically eligible individuals not applying, deliberately heightened requirements of those schools indicating a willingness to accept such students, plus reversals of unfavorable admission policies have led to this clouded picture.

In reality, the actual density per 1,000 students favors the small college. Of all schools reporting, 417 per year, or 0.48 per 1,000 students were registered. Of these 0.91 per 1,000 students were found in schools whose enrollments were 300 or less, 0.57 in those reporting enrollments of 300 to 1,500 and 0.38 in those schools enrolling 1,500 or more.[81]

Of various specified conditions of acceptance:

69 per cent specified that the student must be under "adequate medical care;"

66 per cent said seizures must be moderate;

59 per cent demanded parent responsibility for accidents;

51 per cent demanded preinformation concerning illness;

18 per cent demanded special room arrangements.

Teachers colleges were more insistent on adequate medical care; arts and sciences stipulated the above order; junior col-

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[74] Abraham, Willard, "Educational Problems of College Age Persons with Seizures," *Journal of the International Council for Exceptional Children*, 22(January, 1956), 147–51.

[75] Lennox, "The Higher Education of Epileptics," *op. cit.*

[76] *Ibid.*

[77] *Ibid.*, 597.

[78] *Ibid.*

[79] *Ibid.*

[80] *Ibid.*

[81] *Ibid.*, 598.

leges were more insistent upon mild seizures and parent responsibility; and technical and theological schools largely demanded prior discussion of the case. To the 50 schools who absolutely rejected enrollment of epileptics could be added others who used "unofficial persuasion and advice."

The status of student work showed that 76 per cent of epileptics did favorable work in those institutions answering this question while 24 per cent were doing unfavorably. In schools conditionally admitting epileptic students this percentage of favorable work rose to 86 per cent.

In Abraham's study, published in 1956, the past studies of Lennox and others were reviewed. Although the survey was not as extensive as that by Lennox, several significant factors were pointed out. Of 44 institutions reporting, 37 (84 per cent) said that there was no observable difference in intellectual capacities. This would seem to reinforce the Collins study, mentioned earlier. As to sex incidence, 13 per cent found more among women; 36 per cent found no observable difference; and 51 per cent found more among men. Many felt, however, that their replies were based upon too insufficient an enrollment to be of sound basis for further conclusions.

Epileptic students participated (although to a lesser extent according to this study) [83] in athletics, publications, dramatics, and music and art activities. This would seem to validate the writer's criticism of Lampe's blanket exclusion for epileptic students in these various activities unless seizure symptoms were entirely absent a year.

It was found in this study [83] that epileptic students were preparing for most professional occupations (i.e. accounting, engineering, agriculture, library work, teaching, chemistry, law, etc.)

Because of the succinct nature of Abraham's general conclusions,[84] they are reproduced here, *in toto:*

1. "All colleges and universities do not adhere to the philosophy of equal educational opportunity for every child as far as epileptics are concerned;
2. There should be united efforts of state departments of education, colleges and universities to seek interest, co-operation and understanding of the general public and of the faculties and student bodies;
3. Counseling techniques could be improved with the following kinds of information available to the counselor of the epileptic student:
   a. The nature of the illness
   b. Emotional problems as they relate to epilepsy
   c. The value of consistency in therapy
   d. Employment opportunities
   e. Special legislation pertaining to epileptics
   f. Marriage and bearing children
   g. The effectiveness of modern medicine in the control of epilepsy
   h. Knowledge of the findings of recent research in the field of epilepsy
4. Printed information on recognizing the attacks and what to do in the event of seizures should be available to all faculty personnel;
5. Sound public relations programs need to be put into effect;
6. Academic guidance programs (curriculum, load, choice of subjects) should be organized to meet the special needs of individual epileptic students;
7. Special consideration for housing should be a concern of the institution;
8. Follow-up studies or information concerning what is happening to the epileptic students after leaving college would aid in planning desirable programs for epileptics currently enrolled."

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[83] Abraham, *op. cit.*, 150.

[83] *Ibid.*

[84] *Ibid.*

While it is true, as Lennox points out,[85] that a three-fold increase in epileptic enrollment would still present only one-half or fewer epileptics per college and university in the United States, this thought of self-protection (i.e. keep enrollment down) on the part of many schools deprives at least three times the number of presently enrolled epileptics of college age, having both intelligence and other satisfactory qualifications needed, from attending school each year.

Meeting the increased need for providing knowledge, skills, and self-confidence, acquirable only through advanced training and counseling, stands as a ready challenge to educational and counseling agencies in the United States today.

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[85] "The Higher Education of Epileptics," *op. cit.*, 626.

JOHN ALTROCCHI, PH.D.
CARL EISDORFER, PH.D.

Changes in attitudes toward mental illness

From their extensive investigations of public reactions to mental illness, Nunnally and Osgood (7) have set forth a number of propositions concerning transmission of information about and change in attitudes toward mental illness.

For instance, they propose that attitude changes may occur as a function of increased information about mental illness, the certainty expressed in a message and through contact with the mentally ill. The studies reported in this paper were designed to explore changes in favorableness of attitudes toward mental illness as a function of didactic instruction about mental illness and intensive clinical experience directed toward the learning of psychotherapeutic behaviors with patients.

STUDY I: METHOD AND RESULTS

Three Duke University undergraduate summer school classes were the *S's* of the first study. The experimental group (E) (N=14) was a class in abnormal psychology taught by one of the authors. One control group (C_1)(N=8) was a class in industrial management in the Department of Economics. These students received no instruction about mental illness.

Drs. Altrocchi and Eisdorfer are assistant professors of medical psychology in the Department of Psychiatry and assistant professor and lecturer, respectively, in the Department of Psychology at Duke University, Durham, N. C.

An earlier version of Study I of this paper was presented at the meetings of the Southeastern Psychological Association in April, 1959. A summary of Studies II and III was presented at the meetings of the American Psychological Association in September, 1960. Portions of these studies were supported by a grant from the Duke University Research Council and by Grant M-1599 from the National Institute of Mental Health.

The authors are indebted to the investigators of the latter project and to Jum Nunnally, Henry Weitz, Herbert Hahn, Herman Turk and Louis D. Cohen for their help.

A second control group (C_2)(N=8) was a class in personality development in the Department of Education, this course giving only minor emphasis to mental illness. All groups were tested at the beginning and end of the six-week courses.

The first instrument used—entitled "Information Questionnaire" for this study—was constructed by Nunnally and his coworkers (3,5) to assess general mental health information. *S's* were asked to rate, on a seven-point scale, their agreement with 40 such statements as: "Mental health is largely a matter of trying hard to control the emotions," and "A change of climate seldom helps an emotional disorder."

The two scoring criteria used were: 1) the mean scores of Nunnally's experts (3) on the 10 items on which the experts agreed most highly and; 2) the mean ratings of five clinical psychologists (who did not always agree closely), including both of the authors, on all 40 items.

The second instrument used to assess information—entitled "Personality Descriptions" for this study—is described by Cumming and Cumming (1) and has been used by Nunnally (5). There are thumbnail sketches of six people, all manifesting some mental illness or diagnosable emotional difficulty. For instance:

> "A young woman in her twenties, Betty Smith, has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl. She doesn't talk much to anyone—even her own family—and she acts as if she were afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time and shows no interest in anything or anybody."

Subjects were asked to supply written answers to such questions as: "What do you think makes her act this way?" "Would you say this woman has some kind of mental illness or not?" "Would you say that the mental illness she has is a serious one or not?" In a scoring system developed for this study, each of the six sets of written answers was given one point each for recognition of mental illness, recognition of severity, minimal diagnostic or dynamic understanding, and fairly complete conceptual understanding. Thus there was a maximum of four points for each personality description and 24 for the whole set. All protocols of the students were coded to disguise the identity and pre- or post-status of *S's*. The investigators independently scored a sample of seven protocols, achieving a rank order correlation of .91. All protocols were then scored by one of the authors.

Attitudes were measured by a semantic differential instrument modeled after similar instruments used by Osgood (8) and Nunnally (5). Six concepts were rated: Average Man, Average Woman, Neurotic Man, Neurotic Woman, Insane Man, Insane Woman. The evaluative factor was represented by 13 scales (e.g. good . . . bad), the potency factor by 2 scales (e.g. strong . . . weak), the activity factor by 2 scales (e.g. slow . . . fast) and the understandability factor by 3 scales (e.g. mysterious . . . understandable).

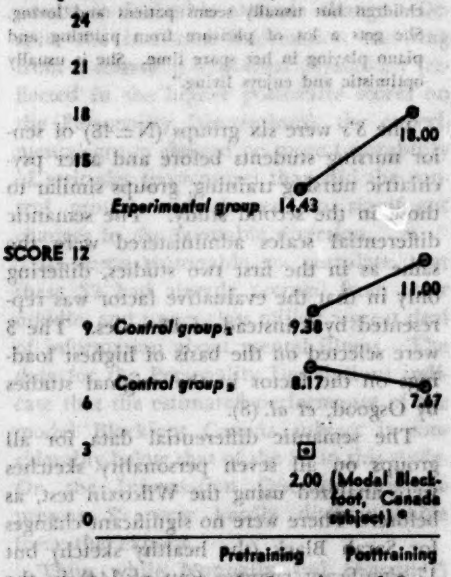
The mean discrepancy between Nunnally's experts and subject groups (precourse) on the 10 Information Questionnaire items on which the experts agreed most highly was compared with the mean discrepancy (postcourse) for each group. No group changed significantly (for E, $t=1.48$; for C_1, $t=.50$; for C_2, $t=1.88$). This analysis thus provided no evidence that any group of *S's* acquired additional information about mental illness from their summer school course. The probable reason is that most of *S's* initially differed very little from the experts on these items.

The number of items on which each *S* moved closer after the courses to the mean of the five psychologists' ratings of all 40 items was also used as a score to indicate increase in information. The mean scores were E=11.64, C_1=10.75, and C_2=11.14. The distributions of scores were almost entirely overlapping, so that again the Information Questionnaire reflected no increase in information about mental illness for any group.

Figure 1 shows the mean scores on the Personality Descriptions pre- and postcourses for all groups. In an attempt to obtain a gross estimate of the extent to which these subjects differed from a sample of the general public, the data presented by Cumming and Cumming (1) for their modal Canadian *S* were scored according to the procedures described above. This score is included in Figure 1.

FIGURE 1

Mean scores on the Personality Descriptions for all groups pre- and postcourse in Study I



* As calculated from data in Cumming and Cumming (1).

A Lindquist (2) Type I analysis of variance of these scores was carried out.[1] While the specific change for E compared to C_1 and C_2 was not significant with N's so small (F for treatments × groups interaction=1.22, NS), the significant group differences ($p<.01$) and treatment effect ($p<.05$) demonstrate that, at least after the courses, differences among the groups were clearly enough reflected on this instrument to make it possible to investigate whether attitude differences were associated with these postcourse differences in information.

The mean scores for each group on the semantic differential factors for the six concepts were calculated.[1] It was immediately apparent that E's postcourse attitudes were not more favorable than those of C_1 and C_2. In fact, for 11 of 16 comparisons, E was lower than one or both of the C groups. Only for the understandability factor was there a tendency for E to manifest more favorable postcourse attitudes. Change was assessed by use of the Wilcoxin matched-pair signed rank test (9).

While there were scattered changes significant at $p \lesssim .05$ in the favorable direction for the control groups (5 of 48), there were no significant changes in the favorable direction for the E group. The significant changes for E were all in the lower direction on the activity factor.

STUDY II: METHOD AND RESULTS

The same semantic differential was administered to six groups (N=75) of senior

[1] Mimeographed copies of all tables for these studies may be obtained on request from Drs. Altrocchi and Eisdorfer.

nursing students from the Duke University School of Nursing who were undergoing 12 weeks of intensive, full-time training in psychiatric nursing. This training was psychodynamically and psychotherapeutically oriented and included didactic lectures and conferences concerning psychiatry and psychopathology, contact with many psychiatric patients and, especially, daily intensive contact with one to three patients, and supervision aimed at helping the student become more aware of the dynamics underlying her own and her patients' behavior.

Four groups (total N=49) made pre- and post-training ratings. Two additional groups (total N=26) made only post-training and then follow-up ratings (six weeks later) in order to assess the persistence of anticipated attitude changes resulting from the training for a period immediately following training as well as to determine whether attitude changes might occur in the post-training period.

The mean semantic differential factor pre- and post-training scores for all groups on all 6 concepts were calculated.[1] Using the Wilcoxin test, only 2 of 48 changes were significant in the positive direction at $p \lesssim .05$ for the "Average Man" and "Average Woman" concepts, but 19 of 96 were significant in the positive direction at $p \lesssim .05$ for the "Neurotic" and "Insane" concepts (2 others were significant in the negative direction).

The favorable changes were not uniform across groups, concepts or factors. As might be expected, the groups tested only at post-training and follow-up showed fewer changes (3 of 32) than did the other groups from pre- to post-training (16 of 64).

Changes were more frequent for "Neurotic" and "Insane Woman" (14 of 48) than "Neurotic" and "Insane Man" (5 of 48). Changes were more frequent for the evaluative factor (7 of 24) and especially the understandability factor (10 of 24) than for the potency factor (2 of 24) and activity factor (2 of 24 in the negative direction).

STUDY III: METHOD AND RESULTS

In an attempt to move from assessing attitudinal reactions to abstract concepts like "Insane Man" and toward assessing attitudinal reactions to real people, and following one of Nunnally's (5) suggestions, *S's* in the third study were asked to react to seven personality sketches—the six from the Personality Descriptions (see the first study) and another designed to depict a relatively healthy person:

> "Sarah Black is a young woman who seems happily married and has three children. Before her marriage she taught in a primary school. Once in a while she and her husband have quarrels but they seem able to work these problems out. She is occasionally irritable with one of her children but usually seems patient and loving. She gets a lot of pleasure from painting and piano playing in her spare time. She is usually optimistic and enjoys living."

The *S's* were six groups (N=48) of senior nursing students before and after psychiatric nursing training, groups similar to those in the second study. The semantic differential scales administered were the same as in the first two studies, differing only in that the evaluative factor was represented by 3 instead of 13 scales. The 3 were selected on the basis of highest loadings on the factor in the original studies by Osgood, *et al.* (8).

The semantic differential data for all groups on all seven personality sketches were analyzed using the Wilcoxin test, as before.[1] There were no significant changes for Sarah Black (the healthy sketch) but 17 significant changes (out of 144) in the positive direction (and 2 in the negative

direction) for the other 6 sketches. Again, the changes were not uniform across groups, sketches, or factors. Group differences have occurred many times with these *S's* and have remained unexplained. There were more changes for FJ, a paranoid, (6 of 24), BS, a very withdrawn girl—see above—(4 of 24), and BG, a delinquent boy, (4 of 24), than for BW, an alcoholic man, (2 of 24), GB, an obsessive man, (1 of 24) or MW, a mildly phobic girl, (2 of 24 in the negative direction).

As in the second study, however, significant changes were more frequent for the evaluative factor (5 of 36 in the positive direction and 2 in the negative direction) and especially the understandability factor (8 of 36) than for the potency factor (4 of 36) and activity factor (1 of 36).

DISCUSSION

The results of the first study do not support the proposition that increased information results in favorable attitude change. Despite the increased information resulting from a course in abnormal psychology (reflected in the higher postcourse scores on the Personality Descriptions), the experimental group showed no more favorability of attitudes (postcourse) than did the control groups and showed no significant changes in the favorable direction.

It seems reasonable to postulate that these *S's* had already accrued from their middle- and upper-class milieu a great deal of information about mental illness. The data for the Personality Descriptions indicate that the estimated performance of the modal Blackfoot Canada subject is considerably below that of the *S's* in this study. On the Information Questionnaire the present *S's* were hardly distinguishable from the experts.

Thus, while Nunnally and Osgood (7) have demonstrated that favorable attitude change occurs where information is supplied to *S's* with relatively low levels of information, positive attitude change at higher levels of education and information may be related to other factors such as more intensive experiential training.

The second and third studies were designed to assess the effects of more intense training and personal experience with mental patients. In these studies there were a number of significant changes in the favorable direction in attitudes toward mental illness as reflected in the semantic differential factor scores.

The question arises as to whether the changes could have resulted from a test-retest phenomenon—i.e. *S's* giving more favorable reactions simply because they were taking the instrument a second time. Two pieces of evidence argue against such an interpretation.

First, if such a phenomenon were operating in the second and third studies, would it not have operated in the first study? Second, if such a phenomenon were operating in the second study, one would expect the initial scores of the groups who were first tested post-training (and then six weeks later) to be closer to the pretraining than to the post-training scores of other groups. This did not occur. Thus, it does not seem likely that the changes were due to a test-retest phenomenon.

The patterns of significant changes and consistencies between the second and third studies appear important. While changes occurred more frequently with female than male concepts in the second study, such a pattern was not apparent in the third study. There seemed to be a pattern in the third study for changes to occur more often regarding sketches involving more severe (or more apparent) psychopathology, but such changes did not occur more

frequently in response to the "Insane" than the "Neurotic" concepts in the second study.[2] There were few changes for concepts of "Average Man" and "Average Woman" in the second study and no changes appeared for the healthiest sketch (and for MW, generally perceived as the next healthiest; Cumming and Cumming, 1, in the third study.

Finally, and more probably most important, in both studies changes were more frequent for the understandability and evaluative factors than for the potency and activity factors. This last pattern seems particularly relevant because it is quite debatable whether favorable changes would be reflected by increases or decreases on the potency and activity factors, particularly for females.

Thus a relatively clear pattern of changes emerged from the results of the second and third studies. Slight changes (rarely more than a point on a seven-point scale for any group) occurred on the understandability and evaluative factors for several of the concepts or sketches reflecting psychopathology and few changes occurred for concepts or sketches reflecting normality or health.

Similar changes, however, were not at all apparent in the E group in the first study. The training in all the studies involved didactic instruction in mental illness, but training in the second and third studies differed by being a full-time experience over a longer period, by emphasizing personal growth and the learning of therapeutic behaviors and a professional status and role, and by including considerable contact with mental patients. These results suggest that it is important to clarify further whether more time, experiential training directed toward the adaptation of certain patterns of behavior, or contact with patients (7) or a combination of these is most responsible for attitude changes.

Assessment of mental health attitude changes in people like those of the present studies, advanced students in undergraduate and nursing schools, would seem to be particularly important because it is such people who are likely to become key caretaking individuals or leaders in communities.

Positive attitudes toward mental health problems and mental illness in such people are important for support of mental health goals and may affect the general population in many ways (10). It is apparent that while the *S's* in the present studies appeared to have a high level of information about mental illness, they did not show markedly different attitudes from the general population (5). For *S's* possessing considerable information (reflecting higher educational achievement and intelligence and middle and upper socioeconomic status) it may be that an increase in information about mental illness is not a sufficient condition for favorable changes in attitudes toward mental illness, but that contact with patients, specific training in dealing with such patients, and/or supervision directed toward self-understanding may be necessary in addition (or perhaps instead).

Some remarks on the four instruments used in these studies appear to be warranted. The Information Questionnaire is easily administered, but the criteria are a function of consensual validation and experts do not always agree. Also it may sometimes assess "opinions" rather than

[2] Although there was virtually no difference in the number of changes for "Neurotic" and the number of changes for "Insane" concepts, attitudes toward "Insane" concepts were consistently less favorable.

information (e.g. "Women are as emotionally healthy as men.")

In the first study no increase in Information Questionnaire scores was reflected in students who performed very well in a course in abnormal psychology. Thus, except for highlighting gross inadequacies of mental health information, the usefulness of the Information Questionnaire may be quite limited. The Personality Descriptions, as scored here, seem useful for reflecting increases in information about mental illness at high levels of education and information, but administration and scoring are more difficult and the scoring heavily weights knowledge of psychiatric language.

Furthermore, rank-order correlations between scores on this instrument and scores on the Information Questionnaire were .38 pre- and .40 postcourse in the first study, so that these two instruments may measure somewhat different kinds of information. Since information regarding mental illness would appear to be wide-ranging in scope, more precise specification of the nature of such information seems necessary in future work. The semantic differential is simple and quick to administer but provides a mass of data which is unwieldy to analyze. In addition, as used in this context, it probably does not always reflect attitudes alone. Thus, whether neurotic men are happy or sad, for instance, is potentially verifiable information.

Finally, how far and in what direction attitudes are clearly favorable is debatable, especially for the potency and activity factors for females. The use of semantic differential scales to assess reactions to brief personality sketches, as in the third study, however, may have considerable potential. In such an important new area, useful instruments are vital. Nunnally and Osgood and their co-workers have done invaluable service in constructing the instruments used here, but improvements and new instruments might be even more useful.

SUMMARY

Three studies were carried out to assess changes in favorableness of attitudes toward mental illness as a function of increased information about mental illness and psychotherapeutic training. Attitudes were measured by a semantic differential. In the first study with three small summer session classes, attitudes toward concepts of "Neurotic Man," "Neurotic Woman," "Insane Man" and "Insane Woman" did not change in the favorable direction. In the second study with 75 nursing students undergoing training in psychiatric nursing, a number of significant changes in the favorable direction were found for attitudes toward the same concepts.

In a third study with 48 similar nursing students, but assessing attitudes toward personality sketches of people with emotional problems, a number of significant changes were found again. In both studies changes were most apparent in the understandability and evaluative factors of the semantic differential.

It is postulated that, with people in the advanced stages of college and nursing training who are relatively well-informed, favorable changes in attitudes toward mental illness are not likely to result from increased information alone but may result from training which also includes contact with patients and the learning of psychotherapeutic behavior.

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LOUISE L. TYLER, PH.D.

Some reflections on learning and personality

The teaching-learning process has been analyzed and studied with regard to the nature of the learner, the type of objectives, the method or media of instruction and the role of the teacher. These topics have been studied by investigators within a psychological framework, within a sociological framework and within an eclectic framework. This author would like to suggest that there are many developments in the related fields of child care, psychiatry and psychoanalysis which have interesting implications for the teaching-learning process. The purpose of this paper, then, will be to point out some of these findings and their implications for the teaching-learning process.

In order to simplify the task of this paper, but, in addition, to highlight certain aspects, only two component parts of the teaching-learning process will be examined, namely:

1. The student's personality and how it influences learning, and

2. The teacher's personality and how it influences learning.

(It is true that although the examination and presentation of material in these two arbitrarily though logically designated sections may not do justice to the complexity of the actual process, this separation does, however, aid our initial understanding.)

There are, of course, many aspects of a student's personality that are of importance for educators; however, two topics only will be given consideration. These are the student's real behavior and the student's projections onto the teacher.

The student's real behavior is an important element in affecting learning. The conception of personality development which may be of significance in providing insight into the learner's behavior is that which psychoanalysis has suggested. The stages of personality development, accord-

Dr. Tyler is assistant professor of education at the University of California, Los Angeles.

ing to the psychoanalyst, are designated as oral, anal, phallic, latency, genital.

Erik Erikson, the psychoanalyst, has suggested another way of viewing the development of personality. He lists eight components or stages as essential to the development of a healthy personality. These eight components are a sense of basic trust, a sense of autonomy, a sense of initiative, a sense of industry, a sense of identity, a sense of intimacy, a sense of parenthood and a sense of integrity. The relationship between Erikson's components and the Freudian conception is obvious. Because we are concerned with schooling, only the first five of these components will be discussed in this section of this paper.

Trust, the first sense, is an attitude toward oneself and the world and is derived from experiences during the first year of life. This sense of trust is related to the oral period of development. At this stage the child lives with his mouth, which is of major importance. Experiences of being hungry, receiving food, and consequently being relieved and comfortable are essential. If this stage is satisfactorily completed, the child learns to trust others and to trust himself.

The second component, the sense of autonomy, develops during the second and third years of life. The significance of this stage lies in the development of the muscular system of the body. During this period, the muscles that "hold on" and "let go" are developed along with the muscles and skills used in walking, talking and manipulating. This sense is related to the anal period of development. Mutual regulation goes on between adult and child so that self-control is developed without loss of esteem.

The third component of a healthy personality, the sense of initiative, develops during the fourth and fifth years of life. The child is on the go; vigorous and independent he moves under his own power. This component is related to the phallic period. The child begins to see Mother and Father in a new way. The little boy sees Mother as someone he wishes to love and possess exclusively. As for the little girl, it is Father she wishes to possess. These conflicts must be resolved or the child is slated for difficulty. It is at this point, too, that the conscience or superego is becoming established.

The fourth component, the sense of industry, develops during the sixth to twelfth years. According to Erikson, "the child wants to be shown how to get busy with something and how to be busy with others" (1). Children at this stage want play and fantasy but they also want work and reality. The sense of industry is related to the latency period. The child during this period appears to be a more civilized person. The child is "educable." An inner balance in the personality structure has been achieved between the id and ego.

The fifth component of a healthy personality comes during the early adolescent years. The youth is flooded by instinctual energy. The balance between the id and ego is being disrupted. In addition, the youth is determining who he is. He identifies with a number of people, occupations and behaviors and eventually integrates all these separate identifications. This sense, along with the sixth sense, intimacy, the seventh sense, parenthood, and the eighth sense, integrity, is related to the genital period of development.

Anna Freud has some insightful comments about adolescence which will be of help to us also. She states:

> " . . . . the ever recurrent question whether the adolescent upheaval is welcome and beneficial as such, whether it is necessary and, more than that, inevitable. On this point, psychoanalytic

opinion is decisive and unanimous. The people in the child's family and school, who assess his state on the basis of behavior, may deplore the adolescent upset which, to them, spells the loss of valuable qualities, of character stability, and of social adaptation. As analysts, who assess personalities from the structural point of view, we think otherwise. We know that the character structure of a child at the end of the latency period represents the outcome of long drawn-out conflicts between id and ego forces. The inner balance achieved, although characteristic for each individual and precious to him, is preliminary only and precarious. It does not allow for the quantitative increase in drive activity nor for the changes of drive quality which are both inseparable from puberty. Consequently, it has to be abandoned to allow adult sexuality to be integrated into the individual's personality. The so-called adolescent upheavals are no more than the external indications that such internal adjustments are in progress" (2).

What are some of the implications for learning from this conception of the development of the child? One implication is that the student's real behavior sets limits. The sense of industry, ages six to twelve, is the time when the student is ready and eager to learn the reading, writing and other intellectual skills that adults use in the world of work. This is the time when the school can and should emphasize knowledge and intellectual skills. Because the child is stable, he is ready for schooling. Similiarly, the adolescent's behavior also sets limits. The upsetting of the inner balance results in swings of mood and behavior. The adolescent will behave inconsistently and unpredictably. The task for him at this stage is to begin developing the structure the adult personality is to take. Much energy is going into bringing about a new resolution between the id and ego; consequently intellectual performance and development may not manifest the stable development that teachers wish. However, even though the adolescent behaves inconsistently (and frequently inconsiderately from the teacher's viewpoint) the school can have as its aim the development of the intellect. As has been pointed out by workers in the field, direct mastery of the adolescent's problems is not available to him. The only alternative is mastery through thought. Therefore, the development of the intellect should be emphasized. Thinking, according to Bettelheim, strengthens the adolescent's ego, while action usually weakens it by defeat because he cannot yet act successfully with regard to his pressing biological, emotional and cultural problems. The school, by emphasizing the development of the intellect indirectly, aids in the structural reorganization of the personality at this difficult time.

The student's projections onto the teacher are also important elements in affecting learning. Every one who has taught has been made aware of the tremendous strength of some of the impulses students transfer to teachers. This is true at all levels—elementary, secondary and higher. This transference may appear more obvious at the elementary level but it is similarly found at the secondary and higher levels. Some of these transferences may enhance learning whereas others may diminish learning.

Common illustrations are the kindergarten youngster who throws her arms around teacher saying, "I love you; do you love me?" Or there is the youngster in second or third grade who is always wanting to be with teacher and comes in to clean up the room, walks teacher to her car, or does errands for her. Or finally, the adolescent boy or girl with the crush on the new, attractive high school instructor and who may manifest it by much daydreaming, by antagonism, by wise-cracks, etc.

According to the psychoanalysts, transference is a displacement of affect from one object to another. These reactions of an

individual stem from earlier experiences with significant individuals—parents, siblings and others—during early formative years. These feelings are primarily a result of the individual's personality and are not due to the environment nor to the people in the environment. If a teacher can remember this she will not be overwhelmed by these strong, unanticipated, uncalled-for reactions. The teacher should know that they are not a result of her behavior. Consequently, she will be able to accept the student's behavior and deal with it appropriately.

The analysts can help the teacher, too, in knowing how to deal appropriately with the learner. One idea analysis has given us pertains to the role of the analyst. According to the psychonanalysts, the role of the analyst is that of an objective, understanding, accepting, nonevaluating, trained adult whose purpose is to help the client recognize and understand himself. To the extent that the analyst is objective, understanding and accepting, he is able to be helpful to a client. The teacher following this concept should be objective, understanding, accepting of the learner's feelings, thoughts and attitudes. She should be able to accept the feelings, positive as well as negative, of the learner. It should, of course, be made clear that because the learner reacts to the teacher as a mother, as a love object, as a brother, it does not follow that the teacher must respond accordingly.

In fact, the teacher is to be as reality oriented as the analyst is, for she is not the mother, not the love object, not the brother. However, the teacher should be able to accept these feelings, for to the extent that she accepts these feelings, thoughts and attitudes, the learner feels free to develop. The advantage to the learner in feeling free to develop is that he does develop and learn and consequently is able to master more and more of his environment. And this increases the strength of his ego.

There are, of course, many aspects of a teacher's personality that are of importance for educators; however, only four will be given consideration in this paper. These are the teacher's real behavior, the teacher's understanding and acceptance of the student's personality and emotional needs, the teacher's understanding and acceptance of her own personality and emotional needs and the teacher's ability to become emotionally involved with students.

It is probably wise to remind ourselves that there have been master teachers prior to the advent of psychoanalysis and that there are excellent teachers now who are totally unfamiliar with current psychoanalytic theory. However, psychoanalytic theory may enable us to understand how these teachers behave and how to account for such excellence. Then, too, psychoanalytic theory may enable the ordinary teacher to improve his effectiveness. This is, of course, assuming that the teacher already has mastered a sufficient number of personal anxieties.

The teacher's behavior has, of course, gone through the same developmental stages described for the learner as well as some additional ones, depending somewhat upon certain factors.

Continuing with Erikson's type of analysis, the sixth component of a healthy personality is that of intimacy. This is possible only after identity has been attained to some extent. Intimacy is sought in friendships, combat, leadership, love and inspiration. While sexual intimacy is a part of this, it is not the whole. These intimate relations must be accomplished by means of one's own resources; that is, on the basis of a sure identity.

The seventh stage of a healthy person is that of parenthood. This sense includes the

sexual mates who combine their personalities and energies in the production and care of offspring. Erikson, however, prefers the term "generativity," which is, as he states:

> "primarily the interest in establishing and guiding the next generation, although there are people who, from misfortune or because of special and genuine gifts in other directions, do not apply this drive to offspring but to other forms of altruistic concern and of creativity, which may absorb their kind of parental responsibility" (3).

The eighth stage of development is that of integrity. Only the individual who has successfully mastered the tasks of the previous stages of development is ready and able to accomplish this task. This stage, according to Erikson, involves many things but, essentially:

> "It is the acceptance of one's own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions . . . a new different love of one's parents, free of the wish that they should have been different, and an acceptance of the fact that one's life is one's own responsibility" (4).

What are the implications of these notions? Here, too, for the teacher as for the child, real behavior sets limits and influences learning. The teacher whose real behavior (a consequence of his biological make-up and experience) is that of an aggressive, masochistic individual will be eliciting intense emotional responses from students.

As Susan Isaacs puts it:

> "The teacher cannot do her work well unless she attracts to herself mainly the forces of love. She must provide generous opportunity for expression of the impulses of destruction, but in a very modified form; for instance, in the rivalry of games, sports, and handiwork. But she must not by her real qualities attract to herself the negative, explosive forces of hatred and aggression" (5).

Also, the teacher who is working at the stage of intimacy in her travel toward maturity may be unconsciously seductive to the young boys in a high school class. A seductive woman teacher can again greatly influence the learning. This kind of behavior will elicit intense emotional reactions on the part of some young men and women. This may result in fantasy, daydreaming or withdrawal on the part of the young men (all dependent upon their own needs) and irritation, inadequacy and rejection upon the part of the girls. Somehow if learning is to go on, the teacher must not, in a super-charged fashion be trying to meet her own emotional needs, with the students as the recipients.

However, the teacher who has mastered the tasks of identity, intimacy and integrity is a healthy personality. This teacher, because her own needs are met or are being met, is able to help the child fulfill his needs in ways which help him to master larger areas of his environment. She is able to open the way to knowledge which she may or may not herself possess. This child's natural urge to know, to be curious, is—with a teacher of this kind—able to be developed. She herself has integrated the desire to know—or curiosity—into her character structure.

A teacher's personality is also an object of identification for the students. The teacher's personality, attitudes, qualities will be assimilated by the student; this is an unconscious process. So, whatever the real personality of the teacher is, to some extent it will be integrated into the student's developing character. If the teachers's real personality involves an interest in knowledge, an acceptance of people of other races and cultures, this will be caught by the students. If, on the other hand, the teacher's attitude is a disinterest in knowledge, in a distrust of people, this, all the

protestations notwithstanding, will be caught by the students.

Teacher's understanding and acceptance of students' emotional needs and their influence on learning can be dramatically highlighted by the following material reported by Ilse Hellman:

> "Once a teacher said to me: 'When I see those 52 children look at me and I know that everyone of them wants something from me, it makes me feel quite weak.' And the other, a little middle-aged woman from an isolated school in Australia where she had everybody in one class from five to fourteen, including a defective, said: 'It's hard work, but you see the fun of it is that each of them wants something from me, that each one needs something quite different, and that I know I can supply it'" (6).

A teacher who reacts by feeling quite weak when her students' needs become apparent to her, is unable to remain in contact with them. This may mean an inability to answer their questions, an inability to have conferences with them, an inability to plan activities for them either individually or in groups. This same teacher may have to run from students, may dislike being stopped by students for questions, may refuse to have meetings, etc. In the latter case described by Hellman, the teacher's acceptance of the students' needs facilitated increased contact with the learners. This means that the possibilities of learning increase.

The explanation behind these two teachers may go back to their very earliest experiences. Teachers who always feel drained and incapable and tense about meeting the needs of learners possibly were not warmly and responsively dealt with as children. In order to love, one must have been loved. In order to feel that one can meet the needs of learners, one must have had many experiences which have taught one this.

This previous illustration also brings us to the consideration of the importance of the teacher's understanding and accepting her own personality and emotional needs. Fortunately, most teachers do not always feel weak when students' needs are encountered. Teachers may feel this way occasionally or at certain times. It is possible that some training might be given which could help teachers with classroom difficulties developing as a result of a lack of understanding and acceptance.

The Institute for Psychonanalysis (Chicago) under the leadership of an analyst from their staff offered a seminar to the faculty of a Chicago college. A small group of the faculty volunteered to participate. Some of the major topics presented were the following: teacher motivation; teacher reactions; development of personality; techniques for enhancement of learning; selection of teacher personnel. However, while the psychonanalytic insights given were helpful, even more valuable was the support, reassurance and aid obtained for handling particular classroom difficulties.

An illustration from the seminar documents this. An instructor (of an education course at the college level) described how she was very logically explaining a point to the class. Noting that one young man looked puzzled and confused, she repeated the explanation. The student now looked disbelieving. So the instrutor began to engage the student in a series of questions, with the purpose of making the answer logically obvious. However, the student was unable to follow the argument. During this time the instructor was becoming more and more irritated and impatient. She was taking up important class time on a relatively minor point. The balance of the class was becoming restless; it was getting near the end of the hour, etc. The student was becoming slightly red of face and displeased

at all this attention. The analyst's usual procedure was to ask that the participants of the seminar elaborate on the particular situation or difficulty that had been encountered. As the situation was described in greater detail than the one above, and as participants began to listen very carefully to what was said and what the analyst said, it was amazing the insight which developed.

In the previous mentioned illustration, one of the analyst's comments was: "You have a logical mind; the boy did not; you are very concerned with the importance of your subject matter; you think he should be, too; you want him to understand; possibly he can't or doesn't want to. This boy is frustrating you and you are reacting with irritation and rage because of this."

One clew presented to the group was invaluable. This was to stop and ask: "Why is this happening?" when we are becoming unpleasantly involved with a student. Just as soon as the "back and forth" with a student was stopped and thinking about the reason for the difficulty was begun, the situation becomes less tense and more amenable to appropriate handling.

Now, to the extent that this instructor understands and accepts that she (1) has a logical mind, (2) is vitally concerned with her subject matter, (3) is highly insistent that students understand her subject and (4) becomes irritated at students for not accepting her logic, she can more appropriately handle classrooms. This seminar was most helpful to the individual participants. It is a technique which would be most useful in inservice education courses.

Our fourth consideration, the teacher's ability to become emotionally involved with students, would appear to have questionable value for educators. It would seem that this should be guarded against. Benjamin Wright, under a U. S. Public Health Service Grant at the University of Chicago Orthogenic School, investigated what persons make good workers in a residential child care program. He studied the attitude of workers toward emotional involvement with children. The method used to determine the attitude of the worker toward emotional involvement was recorded by a Q-sample of 80 statements describing actions a person might take with a child.

Each worker had to arrange these 80 statements to represent ideal child care, selecting statements most ideal for one end of the continuum and placing those least ideal at the other. The attitude Q-sorts were analyzed. The attitudes of beginners doing poorly and of experienced workers were compared. Also, attitudes of workers, ranging from trainees to senior work supervisors and child analyst, were compared. And finally a check was made on the professional development as expressed in attitude toward emotional involvement of promising and unpromising beginners.

The results showed that successful counselors valued such test items as:

> "Encourage him to experiment with me to see how dangerous are his emotions;"
> "Get him to turn his anger on me rather than repress it."

whereas failures valued:

> "Don't get so involved that I can't understand his true motives;"
> "Understand his fears fully before I start to help him with them."

In other words, successful counselors valued emotional involvement; failures rejected it.

Then the Q-sorts of workers, at various points in their professional development, were analyzed. According to Wright:

> "At the beginning of his professional experience he values a certain amount of aloof self-protection ('Understand his fears fully before I start to

help him with them') and tends to reject participating self-sacrifice ('Encourage him to experiment with me to see how dangerous are his emotions'). If he is emotionally suited to succeed, however, he does not value aloof self-protection too highly or reject participating self-sacrifice too much.

The growing worker begins to value participating self-sacrifice in his second year and to reject aloof self-protection by his third . . . the worker . . . becomes an interpersonal participant in the processes among which he is living, availing himself of his own most basic resources to deal with them . . . maturity in child care is suggested by the attitude of supervisors. This group rejects aloof self-protection while valuing participating self-sacrifice more moderately and adding the dimension of accepting the child's primitive behavior" (7).

This study by Wright is extremely fruitful as a source of hypotheses for teachers and for educational research. Is it possible that teachers who become successful are those who would also value emotional involvement? Is it possible that this is equally true at all levels of the educational program? If so, successful teachers are those who have tremendous positive emotional resources which make it possible for them to enter into the life of students.

Some basic concepts from psychoanalysis and child care and their implications for learning have been presented. It is probable that our understanding of the teaching-learning process wll be advanced as the relationship between psychoanalysis and the teaching-learning process is studied more carefully and discussed more critically.

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SIMON DINITZ, PH.D.
SHIRLEY ANGRIST, PH.D.
MARK LEFTON, PH.D.
BENJAMIN PASAMANICK, M.D.

The posthospital psychological functioning of former mental hospital patients

This paper reviews the posthospital psychological functioning of consecutively released female patients six months after discharge from a mental hospital. In addition to the inherent importance of the subject itself, this interest in posthospital adjustment and performance derives from our concern with the social organization and structure of the mental hospital and its consequences for patient and staff behavior.

This program research relating hospital structure and behavior, was initiated by studies of differential ward policies and practices on the ward behavior of patients, the social isolate on the ward, and on the self-images of patients at admission and discharge. In succeeding investigations, differential ward organization was related to the diagnosis and treatment of patients and to the decision making involvement and status and job satisfaction of ward personnel.[1]

The authors are all associated with the Columbus Psychiatric Institute and Hospital, Ohio State University Health Center, Columbus, Ohio. Dr. Dinitz is associate professor, Department of Sociology, and research associate in psychiatry; Dr. Angrist is an instructor, Department of Psychiatry; Dr. Lefton is assistant professor, Department of Psychiatry; Dr. Pasamanick is director of research at CPIH and professor of psychiatry. This study was made possible by National Institute of Mental Health Grant M-2955.

1 *See* Dinitz, Simon, Mark Lefton, Jon E. Simpson, Benjamin Pasamanick and Ralph M. Patterson, "The Ward Behavior of Psychiatric Patients," *Social Problems*, 6(Fall, 1958), 107–15; Dinitz, Simon, Mark Lefton, Jon E. Simpson, Ralph M. Patterson and Benjamin Pasamanick, "Correlates and Consequences of Patient Interaction and Isolation in a Mental Hospital," *Journal of Nervous and Mental*

The logical extension of this research has led us to follow patients returned to the community in order to determine the consequences of differential ward policies and practices on the posthospital performance of patients as well as the critical social and psychiatric variables for posthospital success or failure.

A number of previous investigators have also systematically attempted to evaluate the outcome of mental hospitalization. Adler, Simmons and Freeman, and the Carstairs group in England, among others, have tried to demonstrate the importance of social variables for case outcome and posthospital functioning.[2,3,4]

Simmons and Freeman, in particular, have demonstrated that success or failure in outcome and the level or quality of posthospital functioning are highly related to such familial variables as the expectations of significant others, the availability of role replacements and the type of family—parental or conjugal—to which the patient was returned. Simmons and Freeman also suggested that a crucial variable in case outcome was the differential ability of significant others to tolerate the deviant behavior of former patients.

As a result of the specific focus on ward policies and practices and case outcome, our general investigation is necessarily somewhat different from that of Simmons and Freeman although we are heavily indebted to the latter and have attempted to parallel their work whenever possible. There are three innovations in our study. The first involves the use of a control group of never hospitalized females who were selected for the study on the basis that they resided 10 house numbers away and on the same street as the former patients. The function of this so-called "normal" population was to provide a functioning norm or standard by which to evaluate the performance of former patients.

The second difference pertains to our reliance upon interviews with the former patients as well as with their significant others, rather than with only the latter. The third difference involves psychiatric re-evaluation of a selected group of former patients six months after their hospital release and as soon as possible after our interview with them.

The sample populations in the two studies were also different. Our population consists of consecutively discharged *female* patients from one intensive therapy institu-

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tion. These patients, needless to say, represent the entire range of psychiatric diagnoses, difficulties and treatments to be found in the hospital. The Simmons and Freeman patients were *males*, twenty to sixty years of age, white, native born, nonphysically handicapped, not addicted to drugs and not primarily alcoholics. All were functional psychotics and the majority were schizophrenics.

The preceding introduction has presented an overview of the larger study and its origins. This paper is concerned with only one aspect of the larger study: namely, the psychological functioning of former patients six months after hospital release. Rehospitalized patients will be compared to successful patients[5] on 32 clinical items. High and low functioners among the successful cases will be similarly compared. Finally, data on the functioning of 100 former patients in relation to their controls will also be presented.

METHOD

The study population consists of 287 of the total of 376 female patients discharged from the Columbus Psychiatric Institute and Hospital between December 1, 1958, and July 31, 1959. The 89 cases not included in the study were omitted because (A) they were returned to an address outside the 15-county area served by the hospital or (B) were reinstitutionalized in this hospital or transferred to another hospital in less than 15 days after discharge.

Of the total of 287 study cases, ten patients and their significant others refused to co-operate; in eight cases, only one of the two persons—patient or relative—to be interviewed could be located and in five other cases neither patient nor relative could be found. This sample loss, including the partial cases as losses, amounted to 8.4 per cent. Available data on these cases indicated no significant difference in diagnosis, number of admissions, length of hospitalization, duration of illness or in the distribution of social characteristics (e.g., class, education) of co-operating and nonavailable patients.

As already noted, patients were interviewed six months after release. At that time it was found that 41 had been reinstitutionalized within the six-months period. Of these, three had been rehospitalized at least twice.

THE INSTRUMENTS

Three schedules were developed and pretested prior to the study. These included a patient schedule, one for significant others and one for the significant others of "returnees" or rehospitalized patients. The significant other schedules consisted of four measures of patient performance: domestic functioning; work performance; social participation in relation to that of her husband; her psychological functioning including symptoms derived from the Lorr Psychiatric Rating Scale and those previously utilized by Simmons and Freeman.

All schedules paralleled each other in soliciting responses to indices dealing with expectations held by the patient—and her significant other—and tolerance of deviance.

The instruments also included a very complete inventory of background variables. A separate schedule sought to confirm these data from hospital records and still another allowed interviewers to rate the patient and significant other on such variables as degree of co-operation, alert-

[5] Successful outcome refers to a patient's ability to remain in the community for at least six months after hospital discharge. Returnees include those patients who remained in the community for at least 15 days but less than six months after discharge.

ness, and contact with reality during the interview. Finally, the Lorr Psychiatric Rating Scale was used to evaluate the patients who were brought back for the psychiatric re-evaluation.

THE INTERVIEWS

The instruments were pretested both in the hospital and in the community and with both patients and significant others. Nine patients were interviewed initially while still hospitalized. Eight former patients and a relative of each were studied in the community. After major revisions of the schedules—based on these experiences—nine interviewers were selected and trained to collect the data. The same interviewers also collected the data on the controls.

Each of these interviewers is employed full-time as a psychiatric social worker in one of the available public or private faciiities in or around Columbus, Ohio. Each interviewer had volunteered for the work and each devoted his or her afterwork and weekend periods for the interviewing. The very small refusal rate is a tribute to their skill and persuasiveness in tracking former patients and in securing their co-operation.

Two training sessions were arranged for the prospective interviewers. They were informed of the general purpose of the investigation but not of specific hypotheses involved. Each was then given a test case (patient and significant other) to interview. The schedules were discussed item by item prior to and following the test case.

The procedure itself was routinized. First, a letter was sent from the hospital stating the purpose of the interview and containing a postcard (to be completed by the patient) suggesting a time at the patient's home for the interview. Nearly 30 per cent complied. In all instances, the interviewer had to arrange his own specific appointment. When excessive difficulty was experienced in establishing an appointment or when successive failures to achieve the interview were recorded, the case was reassigned to another staff interviewer. Only after failure on the part of the second interviewer was the case listed as a refusal.

Patients and significant others were interviewed separately, though in the same setting, to minimize contamination of response. Patient interviews ranged from 25 to 60 minutes and significant other interviews from 40 to 90 minutes. At the conclusion of the interview an appointment was made with those patients selected for this purpose, to appear for the psychiatric re-evaluation.

Finally, two other procedural points should be mentioned. The first of these concerns circularizing all referring physicians that their patients were being followed up in the community and obtaining their consent for us to proceed. None refused.

The second concerns interviewer reliability. One cross check was run for each interviewer. After completion of the case, a second interviewer was given the same case to interview. Female interviewers were assigned cases completed previously by males and vice versa. The time lag between interview and reinterview was also varied from 15 days to 117 days. Despite this, the reliability across all items on these repeat cases was very high.

THE HOSPITAL SETTING

All patients were drawn from the Columbus Psychiatric Institute and Hospital. This short-term, intensive therapy institution (average length of stay is 45 days) contains five wards and 126 beds. Three of the wards are for female patients and these contain 77 beds. The emphasis of the hospital, in addition to its intensive care aspect, is on teaching and research.

Almost all patients are received as voluntary admissions and as physician-referred cases and two-thirds of the patients represent first admissions to any state mental institutions. Female patients average about thirty-six years of age, are preponderently of lower middle-class status, have attended or completed high school, are married and function as housewives. Nearly 90 per cent are urban and Protestant. Over two-fifths of the female patients are diagnosed as psychotics, principally schizophrenic, while 36 per cent are diagnosed as psychoneurotic and 15 per cent as characterologically disturbed, with the remainder being classified rather diversely.

As previously noted, psychiatric orientation and policies and practices differed considerably from one ward to another. Considerable variability existed in the diagnosis given patients, in the percentage of patients receiving the various therapies, in the assignment of patients to nonmedical therapies, in the length of hospitalization of patients, in the percentage leaving without medical consent and in the type of discharge given the others.

Prior to this study, the hospital had no systematic follow-up care program for former patients. Staff members and residents sometimes maintained outpatient care contacts but these were unsystematic and subject to the discretion of the therapist.

FINDINGS

The findings to be presented in this paper are concerned solely with the psychological functioning of 265 cases on whom complete data were gathered six months after hospital discharge. Three sets of data will be analyzed.

These involve (A) a comparison of the psychological functioning of successful outcome patients and those who were reinstitutionalized, (B) a comparison within the successful outcome cases of the "good" and "poor" functioners and (C) a comparison of the first 100 patient cases and their controls.

The latter, as previously indicated, reside on the same street and 10 house numbers distant. None of the controls has ever been institutionalized or, as far as we can determine, involved in psychiatric treatment.

SUCCESSFUL AND REHOSPITALIZED PATIENTS

One of the major propositions emanating from the Simmons and Freeman studies is that there should be little if any difference in the functioning of successful and rehospitalized male patients. Rather, rehospitalization should primarily be correlated with the degree to which significant others are willing and able to tolerate deviance in behavior.

Our data do not wholly justify this conclusion. In general, rehospitalized patients seem far more impaired than do the successful cases. Before undertaking this analysis, however, it should be stressed that there were some rehospitalized patients who functioned as well or better than those not rehospitalized. By the same token, a significant percentage of the nonrehospitalized patients were functioning at a very low level and could and perhaps should have been rehospitalized.

Nonetheless, the rehospitalized patients, as a group, were decidedly inferior in their functioning to the successful cases, as a group. On the 32 items comprising the psychiatric (psychological) functioning index, the mean functioning score of the returnees was 75.2 which was significantly lower ($P < .001$) than the mean (86.0) for the successful cases.

TABLE 1

Distribution of psychiatric symptoms among successful and rehospitalized patients

Psychiatric symptom	Per cent of successful patients (N = 228)	Per cent of returnee patients (N = 38)	P
A. Makes no sense when talking	15%	53%	.01
B. Walks, sits or stands awkwardly	11	40	.01
C. Moves around restlessly	56	90	.01
D. Swears, curses, often compared to other women	19	37	.05
E. Always seems worn out or tired	74	90	..
F. Tries to hit or hurt someone	9	16	..
G. Lacks control of toilet habits	5	5	..
H. Hears voices	4	29	.01
I. Does not want to see people	35	82	.01
J. Just hangs around the house doing nothing	36	61	.01
K. Tries to hurt or kill herself	4	21	.01
L. Gets drunk often	7	24	.01
M. Gets grouchy or bad-tempered	59	63	..
N. Misbehaves sexually	6	11	..
O. Needs coaxing to do what's expected of her	28	53	.01
P. Has trouble going to sleep	53	84	.01
Q. Takes many pills	17	50	.01
R. Needs help dressing, bathing or going to the toilet	8	13	.05
S. Does not know what goes on around her	7	40	.01
T. Acts tense or nervous	76	97	.01
U. Thinks she is sinful or evil compared to other people	12	40	.01
V. Thinks people want to control or harm her	18	37	.05
W. Worries about her bodily organs	29	37	..
X. Mumbles or talks to herself	12	13	..
Y. Tries to get her way by saying she has pains	15	34	.05
Z. Gets depressed suddenly	56	84	.01
AA. Says she sees people who are not there	2	24	.01
BB. Worries about her health	50	58	..
CC. Teases and picks on people	14	8	..
DD. Thinks people are watching her or talking about her	22	42	.05
EE. Expects bad things to happen in the future, without good reason	20	55	.01
FF. Does not eat well	33	68	.01
Mean Score	86.0	75.2	.01

The 32 items were individually analyzed. These results are shown in Table 1.

Of the 32 items, 23 significantly differentiated the returnees from the successful cases. In each of these instances, the returnees were functioning more poorly than the successful cases. The symptoms attributed to a much larger percentage of returnees than of successful cases involved impairments in speech patterns, motor behavior, quality of language, hallucinations, social isolation, somatic complaints and contact with reality. From this analysis it is clear that returnees (A) evince a greater number of symptoms related to impairment of functioning and (B) show a greater degree of impairment in these various areas than do nonrehospitalized former patients. Quite apart from other considerations, therefore, it is fairly clear that returnees seem to be "sicker" than cases remaining in the community.

Of the nine items which failed to differentiate the two groups, three specified exceedingly severe symptoms (incontinence, physical aggression and confusion) which

occurred too infrequently in either group to be discriminating. The remaining six items were poor differentiators for the opposite reason: namely, that they occurred with great frequency in both groups (e.g., tired, grouchy, concern with bodily organs and concern with health).

LOW AND HIGH FUNCTIONERS IN THE COMMUNITY

Using the same 32 psychological functioning items it was possible to classify the nonrehospitalized patients into the categories of low, moderate and high functioners containing 72, 74 and 82 patients respectively. The functioning mean scores for the three groups were 77.0, 87.2 and 92.9 respectively and each was significantly different in mean score from the other.

For the purposes of this analysis, only the low and high functioners were compared.

The results, presented in Table 2, are very revealing.

Only one of the 32 impairment symptoms failed to differentiate these two groups. This item, specifying attempts at suicide,

TABLE 2

Distribution of psychiatric symptoms among low and high community functioners

Psychiatric symptom	*Per cent of low functioners (N = 72)*	*Per cent of high functioners (N = 82)*	*P*
A. Makes no sense when talking	38%	2%	.01
B. Walks, sits or stands awkwardly	28	2	.01
C. Moves around restlessly	85	22	.01
D. Swears, curses, often compared to other women	40	5	.01
E. Always seems worn out or tired	92	49	.01
F. Tries to hit or hurt someone	18	2	.01
G. Lacks control of toilet habits	15	0	.01
H. Says she hears voices	10	0	.05
I. Does not want to see people	68	12	.01
J. Just hangs around the house doing nothing	71	9	.01
K. Tries to hurt or kill herself	7	1	..
L. Gets drunk often	18	0	.01
M. Gets grouchy or bad-tempered	79	35	.01
N. Misbehaves sexually	13	1	.05
O. Needs coaxing to do what's expected of her	61	0	.01
P. Has trouble going to sleep	72	31	.01
Q. Takes many pills	31	1	.01
R. Needs help dressing, bathing or going to the toilet	8	0	.05
S. Does not know what goes on around her	18	1	.01
T. Acts tense or nervous	92	50	.01
U. Thinks she is sinful or evil compared to other people	26	1	.01
V. Thinks people want to control or harm her	49	1	.01
W. Worries about her bodily organs	57	6	.01
X. Mumbles or talks to herself	28	1	.01
Y. Tries to get her way by saying she has pains	40	0	.01
Z. Gets depressed suddenly	90	24	.01
AA. Says she sees people who are not there	7	0	.05
BB. Worries about her health	74	22	.01
CC. Teases and picks on people	35	2	.01
DD. Thinks people are watching her or talking about her	50	2	.01
EE. Expects bad things to happen in the future, without good reason	40	4	.01
FF. Does not eat well	47	11	.01
Mean Score	77.0	92.9	.01

TABLE 3

Distribution of psychiatric symptoms in patient and control groups

Psychiatric symptom	*Per cent of patients (N = 100)*	*Per cent of controls (N = 100)*	*P*
A. Makes no sense when talking	15	14	..
B. Walks, sits or stands awkwardly	12	20	..
C. Moves around restlessly	62	50	..
D. Swears, curses, often compared to other women	23	7	.01
E. Always seems worn out or tired	76	61	.05
F. Tries to hit or hurt someone	11	1	.01
G. Lacks control of toilet habits	7	5	..
H. Hears voices	5	2	..
I. Does not want to see people	40	28	..
J. Just hangs around the house doing nothing	40	20	.01
K. Tries to hurt or kill herself	5	0	..
L. Gets drunk often	10	3	..
M. Gets grouchy or bad-tempered	54	57	..
N. Misbehaves sexually	6	0	.05
O. Needs coaxing to do what's expected of her	29	14	.01
P. Has trouble going to sleep	50	26	.01
Q. Takes many pills	22	9	.05
R. Needs help dressing, bathing or going to the toilet	4	2	..
S. Does not know what goes on around her	7	5	..
T. Acts tense or nervous	78	62	.05
U. Thinks she is sinful or evil compared to other people	13	2	.01
V. Thinks people want to control or harm her	19	0	.01
W. Worries about her bodily organs	27	12	.01
X. Mumbles or talks to herself	14	6	..
Y. Tries to get her way by saying she has pains	18	5	.01
Z. Gets depressed suddenly	57	28	.01
AA. Says she sees people who are not there	3	2	..
BB. Worries about her health	42	24	.01
CC. Teases and picks on people	18	3	.01
DD. Thinks people are watching her or talking about her	22	3	.01
EE. Expects bad things to happen in the future, without good reason	24	1	.01
FF. Does not eat well	37	18	.01
Mean Score	85.18	90.45	.01

occurred in five of the 72 low functioning former patients and one of the high functioners. All other items or symptoms clearly distinguished the two populations.

Thus far it is possible to suggest that a continuum of impairment exists and can readily be determined on a behavioral manifestation basis. On the extreme end are the very low functioning returnees (18 of the 38 rehospitalized cases). These are followed by the 72 low functioners who remained in the community, the 20 high functioning rehospitalized cases, the 74 moderately well-functioning expatients and the 82 high functioners. (The relation of prehospital and posthospital factors and functioning will be treated in another paper.)

Of particular interest to the authors, however, is that this series of symptoms by differentiating patients, both quantitatively and qualitatively, constitutes a useful index for studies of psychological impairment.

FORMER PATIENTS AND CONTROL CASES

The final analysis to be presented involved a comparison of 100 former patients who succeeded in remaining in the community

and their matched (by street address) controls.

The results, shown in Table 3, indicated that 20 of the 32 symptom items significantly differentiated the patients from their controls.

The patients, according to their significant others, exhibited numerically more of the symptoms and, although not shown in the table, a greater severity of impairment on almost all of the statistically significant symptoms. The mean functioning score which combines qualitative and quantitative differences was 85.18 for the patients and 90.43 for their controls. This difference could have occurred by chance alone much less often than once in a thousand times.

A more detailed inspection of Tables 1 and 3 will also reveal that 13 symptom items differentiated not only the patients and controls but the rehospitalized and successful cases among the patients. These symptoms included swearing or cursing, hanging around the house doing nothing, frequent intoxication, difficulty in getting to sleep, pill taking, nervousness, feeling of sinfulness, concern with bodily organs and similar problems.

Indeed, these are the types of symptoms which, in terms of the index, are only moderately severe—the intermediate types of symptoms between those which are extremely difficult or dangerous for a significant other to tolerate and those which many significant others see themselves as tolerating, e.g., a grouchy or bad-tempered wife.

Four items in the index failed to differentiate both the patients and controls and the rehospitalized and community patients from each other. These symptoms included the aforementioned grouchiness or bad temper item, incontinence, mumbling or talking to self and seeing nonexistent persons. It is likely, however, that when all the data are available and the sample sizes are increased, two of these items—incontinence and mumbling to self—will be useful symptom categories.

On the other hand, the motor behavior items and such extreme symptoms as inability to dress, lack of contact, and attempted injury to self, which did differentiate the rehospitalized and community patients, failed to do so for the community patients and their controls.

It is possible to tentatively interpret these preliminary results as meaning that after hospitalization the more severely impaired former patients are able to perform sufficiently well to satisfy the minimum demands made upon them by significant others but not nearly as well as their neighbors.

The impairments of the patients as contrasted to their neighbors seem to be of a chronic, low degree of visibility type. The impairments are not bizarre, not particularly dangerous to self or others, not primarily incapacitating in nature and hardly likely to be unduly disturbing to a significant other who has lived with these problems—sometimes when even more exaggerated—in the past.

On the other hand, because of the previous hospital experience of the patients, their significant others may be more cognizant and more willing to report these symptoms and difficulties to interviewers who represent the hospital than are significant others of the controls. Whatever the explanation, and there are several in addition to those suggested, patients who remain in the community are functioning at a level significantly below that of the norm group: namely, their neighbors.

SUMMARY AND CONCLUSIONS

A follow-up study of female patients consecutively discharged from the Columbus

Psychiatric Institute and Hospital in an eight-month period was reported. The patients and their significant others were interviewed by psychiatric social workers six months after discharge. A series of scales and indices were utilized in the interview. These included a 32 symptom index of psychiatric functioning derived in part from modifications in the Lorr Psychiatric Rating Scale and from the instruments previously utilized by Simmons and Freeman.

Measures of item and interviewer reliability were obtained. Each patient was matched with a neighbor who resided 10 house numbers away on the same street in order to evaluate the functioning of patients in relation to the functioning of never hospitalized controls.

The results indicated that the 38 rehospitalized patients were qualitatively and quantitatively more ill prior to their rehospitalization than the 230 successful cases. Rehospitalized patients scored significantly lower on the psychological functioning scale; they were differentiated from the successful cases on 23 of the 32 individual symptoms of impairment which comprised the scale.

This impaired functioning probably explains the rehospitalization of half of the hospital returnees. It fails to explain why the other half of the returnees, who were functioning at a level comparable to that of some of the more successful outcome cases, also were rehospitalized or why some seriously impaired expatients were not rehospitalized but remained in the community.

The second analysis involved a comparison of the 72 low and 82 high functioners among the former patients. These groups were found to function differently on 31 of the 32 individual symptom items. Every comparison favored the high functioners beyond any question. The implications to be derived from this are (A) that it is possible to determine the level of discharged patient functioning without resort to very intensive, time-consuming and costly methods and (B) that the level of functioning is not in itself sufficient to determine rehospitalization.

The last analysis compared 100 former patients and their matched (by street address) controls. The results indicated that while neither group exhibited the more extreme and incapacitating symptoms often associated with mental illness, important differences did exist between the two groups.

The controls had fewer of the 32 symptoms and a lesser intensity on those which they did have. Twenty of the 32 symptoms indicated the significantly superior functioning of the control or norm subjects. This initial, rather limited, small sample comparison was tentatively interpreted to mean that former patients, relative to their controls, continue to indicate moderate, probably chronic, low level, low visibility types of impairment after hospitalization.

That they remain in the community is probably more a function of the attitudes of significant others toward them than of their own socially and psychologically adequate behavior. It was also suggested that the significant others of patients might be more sensitive to these symptoms as they are reflected in the behavior of the patients and might be more willing to report them to the interviewers who represented the hospital.

LAURA C. TOOMEY, PH.D.
MARVIN REZNIKOFF, PH.D.
JOHN PAUL BRADY, M.D.
DWIGHT W. SCHUMANN, B.S., R.N.

Attitudes of nursing students toward psychiatric treatment and hospitals

Current thinking about psychiatric treatment places increasing emphasis on the influence of attitudes. A group of studies done recently at the Institute of Living has investigated certain attitudes of patients toward their treatment, and the relationship of these attitudes to success of treatment (1, 2, 7).

Equally important are attitudes of staff members involved in psychiatric treatment. Such writers as Carl Rogers feel that the attitude of the psychotherapist about his patients and his work is of paramount importance to the psychotherapeutic process (8). Extending this view to the therapeutic community of a psychiatric hospital, it can be inferred that the attitudes of every member of the staff surrounding the patient toward various aspects of the hospital setting are relevant to the therapeutic atmosphere. Of particular importance, then, would be the attitudes of ward personnel with whom the patients spend a large part of their waking time, both on and off the ward.

Several recent studies have investigated attitudes of nurses and other psychiatric hospital personnel toward various aspects of their work (3, 4). These investigations, however, have primarily concerned the relative importance of such different facets of a nurse's duties as administration, physical

Dr. Toomey, Dr. Reznikoff and Mr. Schumann are all associated with the Institute of Living in Hartford, Conn. Dr. Toomey is a research associate; Dr. Reznikoff is director of clinical psychology; Mr. Schumann is assistant director of nursing education. Dr. Brady is a research psychiatrist at Indiana University Medical Center, Indianapolis.

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care of patients, and meeting emotional needs of individual patients. The present authors felt that more basic attitudinal trends would involve general opinions and feelings about psychiatric treatment and hospitalization itself. Thus, their aim was to elicit staff attitudes concerning such matters as the efficacy of confinement and treatment in the psychiatric hospital.

The present study was directed toward describing and measuring attitudes of nursing students toward psychiatric hospitals, psychiatrists, and psychiatric treatment in order to get some idea of the over-all attitudinal atmosphere prevailing among this staff group. In addition, the study was designed to determine how such attitudes are influenced by the experience of a three-month affiliation in a psychiatric hospital. Finally, it was hoped that some broad comparisons could be made with the results of previous studies of patient attitudes toward the same areas and their changes during psychiatric hospital experience. While direct comparison is difficult because of background differences, it was hoped that some idea could be obtained of relative attitudinal outlook and stability in the two groups.

Because students work in the hospital for a comparatively short time, they have the opportunity to form only relatively temporary relationships with individual patients. Nevertheless, students play a particularly important role in the day to day life of patients, because to them falls much of the responsibility for individual patient care: they help in personal hygiene, provide companionship in on-unit activities, and often escort patients to treatments, classes, athletic activities and other off-unit appointments, whereas the permanent personnel is likely to be occupied to a greater extent with administrative functions and more impersonal contacts with patients.

Nursing students were chosen for study both because of their importance in patient care, and because they were readily available for assessment as a group. In addition, the relative homogeneity of the nursing student group, in terms of age, sex, education, and occupation, made them suitable for an exploratory study of attitudes, since variation and fluctuations in attitude were expected to be reasonably consistent for the group.

METHOD

Psychiatric Attitudes Battery

This battery of psychological tests was constructed to assess attitudes in three interrelated areas: namely, toward psychiatric hospitals, psychiatrists, and psychiatric treatment. The Psychiatric Attitudes Battery is made up of four tests; the first three were developed by the writers:

(1) The Picture Attitudes Test, which is a projective technique modeled after Murray's Thematic Apperception Test (5) and which consists of cards exemplifying two basic situations: the Patient-Doctor card and the Psychiatric Hospital card;

(2) The Sentence Completion Attitudes Test;

(3) The Multiple Choice Attitudes Questionnaire; and

(4) The Souelem Attitude Scale (9).

These tests are designed to elicit responses which may be scored in terms of over-all *favorableness* of attitudes; i.e., trust or confidence in psychiatric treatment, and degree of competence or sincere interest imputed to psychiatrists and to the hospital as a whole. Since it was felt that favorableness of attitude might vary greatly at difference levels of consciousness, the battery includes tests directed at both conscious and more deep-seated attitudes; the Picture Attitudes Test is designed to elicit the less

conscious attitudes, and the other tests, progressively more conscious attitudes.

In addition to the dimension of general favorableness of attitudes, the battery is also susceptible to the analysis of several more specific attitudinal factors, including: (1) perception of the psychotherapeutic situation (pleasurable, neutral, or unpleasurable), (2) perception of the patient's role in therapy (active or passive), (3) perception of the psychiatrist (supporting, ambivalent, or hostile), (4) perception of the psychiatric hospital (protective, neutral, threatening), and (5) expectation of outcome of psychiatric hospital treatment (high, moderate, or low expectation of improvement). Finally, the Picture Attitudes stories were rated in terms of (6) affective intensity, or degree of emotional involvement and identification with the story, and (7) formal characteristics, or intellectual control, reflected in completeness, coherence, and elaboration of the story.

The complete battery, together with detailed instructions for administration and scoring, and data relative to its standardization and reliability, has been published elsewhere (6). In this study two additional ratings were made on the Picture Attitudes Test; the "Psychiatric Hospital" card as well as the "Patient-Doctor" card was scored for "affective intensity" and "formal characteristics," and combined indices were computed by adding the two ratings for each index.

Subjects

Two groups of affiliate nursing students, a total of 99, were the subjects in the study. Slightly smaller numbers were included in the analysis of some indices, since a few students gave responses that were incomplete or unscorable in certain respects, and a few students left the Institute of Living before their affiliation was completed. The smallest number for any item was 92. These students came to the Institute from 10 different schools of nursing in Connecticut and Massachusetts. Their ages were from eighteen to twenty-one, most being nineteen or twenty. All were high school graduates, and 32 had had at least some college. All were female.

Administrative procedure

The Psychiatric Attitudes Battery was administered to the nursing students during approximately the first week of their psychiatric affiliation, and again shortly before the end of their three-month stay at the Institute. All students in two successive affiliating groups were tested in a group situation.

Combining of groups

Before proceeding with the analysis of the data, it was necessary to establish that it was in order to treat the two groups of subjects together. Nursing students come to the Institute of Living for a 12-week affiliation; the two groups involved in the study were two successive affiliating groups who were at the Institute of Living in the early part of 1958. The composition of the two groups, in terms of age, education, and exposure to psychology courses, was essentially equivalent. The groups did differ somewhat in terms of schools of origin, three schools represented in the second group not being represented in the first.

The two groups were compared by *t*-tests for mean scores on test, retest, and change for each of the attitude measures. While some significant differences were obtained, these were neither in a consistent direction nor in a particular attitudinal area. When the groups were equated for school of origin, and *t*-tests recomputed, the pattern of

significant differences was essentially unchanged. Because of the inconsistency and scattering of differences, and because they could not be attributed to any known difference in characteristics of the two groups, it was presumed appropriate to pool all students for this exploratory study.

RESULTS AND DISCUSSION

Picture Attitudes Test

Nursing student attitudes: The distribution of test and retest scores on the Picture Attitudes Test is shown in Table 1. Table 2 summarizes the distribution of changes in scores between the first and second testing.

The first two indices, *affective intensity* and *intellectual control*, indicate characteristics of the structure of the stories themselves rather than attitudes per se, and thus can be inferred to reflect something of the subjects' attitudes toward taking the test battery.

Table 1 indicates that the "affective intensity" of nursing students' stories initially tended to be moderately high in terms of the rating scale values, whereas at the close of their psychiatric affiliation, the students more often than not refrained from deep emotional involvement in their stories.

Intellectual control exhibited in nursing students' stories shows the same tendency: initially stories were usually complete, coherent, and well-elaborated; at retest they were less so, although still generally above average. Table 2 shows these trends in another way: the first two indices shifted in the direction of decreased control and involvement more often than they increased. Test-retest differences were analyzed by *t*-tests of the mean differences; both *affective intensity* and *intellectual control* were found to have decreased significantly (see Table 9).

TABLE 1

Test and retest scores for nursing students on Picture Attitudes Test

		% Distribution	
Index	*Attitude score* *	*Test*	*Retest*
Affective intensity†	Very high	18	2
	High	23	12
	Medium	32	30
	Low	14	35
	Very low	13	21
Intellectual control†	Very high	24	13
	High	19	26
	Medium	44	37
	Low	8	16
	Very low	5	8
Therapy situation	Pleasant	18	24
	Neutral or ambivalent	68	69
	Unpleasant	14	7
Patient activity	Active	16	15
	Active and passive	60	50
	Passive	24	35
Psychiatrist	Helpful	79	72
	Neutral	19	26
	Threatening	2	2
Hospital situation	Helpful	27	45
	Neutral	56	41
	Threatening	17	14
Outcome†	Very favorable	34	40
	Favorable	43	31
	Neutral	21	27
	Unfavorable	2	1
	Very unfavorable	0	1

* Scores are on a continuum, ranging from 1 to 5†, with a low score representing a more favorable attitude and more affective intensity and intellectual control.

† The *affective intensity*, *intellectual control*, and *outcome* indices were derived by summing the scores for both Picture Attitude stories and hence range from 2 to 6 rather than from 1 to 3.

It may be hypothesized that these formal changes indicate less positive attitudes, at least toward the test-taking situation, in that students' inclination and ability to tell

TABLE 2

Change in nursing student scores on Picture Attitudes Test (from initial testing to retesting)

	% Distribution of attitude score change				
Index	*Much more favorable*	*More favorable*	*No change*	*Less favorable*	*Much less favorable*
Affective intensity	1	18	24	47	10
Intellectual control	1	22	40	32	5
Therapy situation	2	29	52	14	3
Patient activity *	2	24	38	33	3
Psychiatrist	1	14	64	20	1
Hospital situation	4	30	50	16	0
Outcome	0	22	60	16	2

* The categories for this particular index are "Much more active," "More active," "No change," "More passive," "Much more passive."

well-structured elaborated stories with emotional identification decreased.

The remaining Picture Attitude indices reflect qualitative attitudes toward psychiatric hospitals, psychiatrists, and psychiatric treatment. The *therapy situation* (i.e., psychotherapy) was seen in a predominantly neutral light both before and after psychiatric affiliation (Table 1), and the students' views either did not change or changed by a small amount (Table 2).

Patient activity scores indicate that the patient's role in psychotherapy was usually thought of as both active and passive at both testings, and that it tended to be somewhat more often thought of as passive rather than active, especially at retest.

The *psychiatrist* was seen as helpful and supporting in a large majority of cases; there was a slight shift to a more neutral view at retest, possibly reflecting development of a more realistic idea of psychiatrists during three months of psychiatric experience.

The *hospital situation* was initially seen in a neutral light, but at retest was seen as generally favorable and pleasant; changes were primarily in the favorable direction.

A favorable *outcome* of treatment was generally anticipated; only two of the 90-odd students suggested an unfavorable outcome at either testing.

Analysis by *t*-tests indicated that only one of these indices, "hospital situation," changed significantly (Table 9).

Comparison with patient attitudes: Because of the radically different composition of the patient and student groups (in age, sex, education, previous experience with hospitals and treatment, etc.), precise statistical comparisons are not appropriate. Nevertheless, some descriptive comparisons can be made.

Table 3 compares attitudes, as elicited by the Picture Attitudes Test, for patients and nursing students at comparable times, i.e., within a week or two after their arrival at the Institute of Living. (Comparisons of the two groups on *affective intensity* and *intellectual control* were omitted, because these two indices were not applied to patient-data in a comparable fashion.)

The attitudes of the two groups toward the *therapy situation* are roughly comparable. Students tend to hold more fa-

FIGURE 1

PERCENTAGE DISTRIBUTION OF STUDENT SCORES ON THE SENTENCE COMPLETION TEST (TEST & RETEST)

Test ——— Retest – – – –

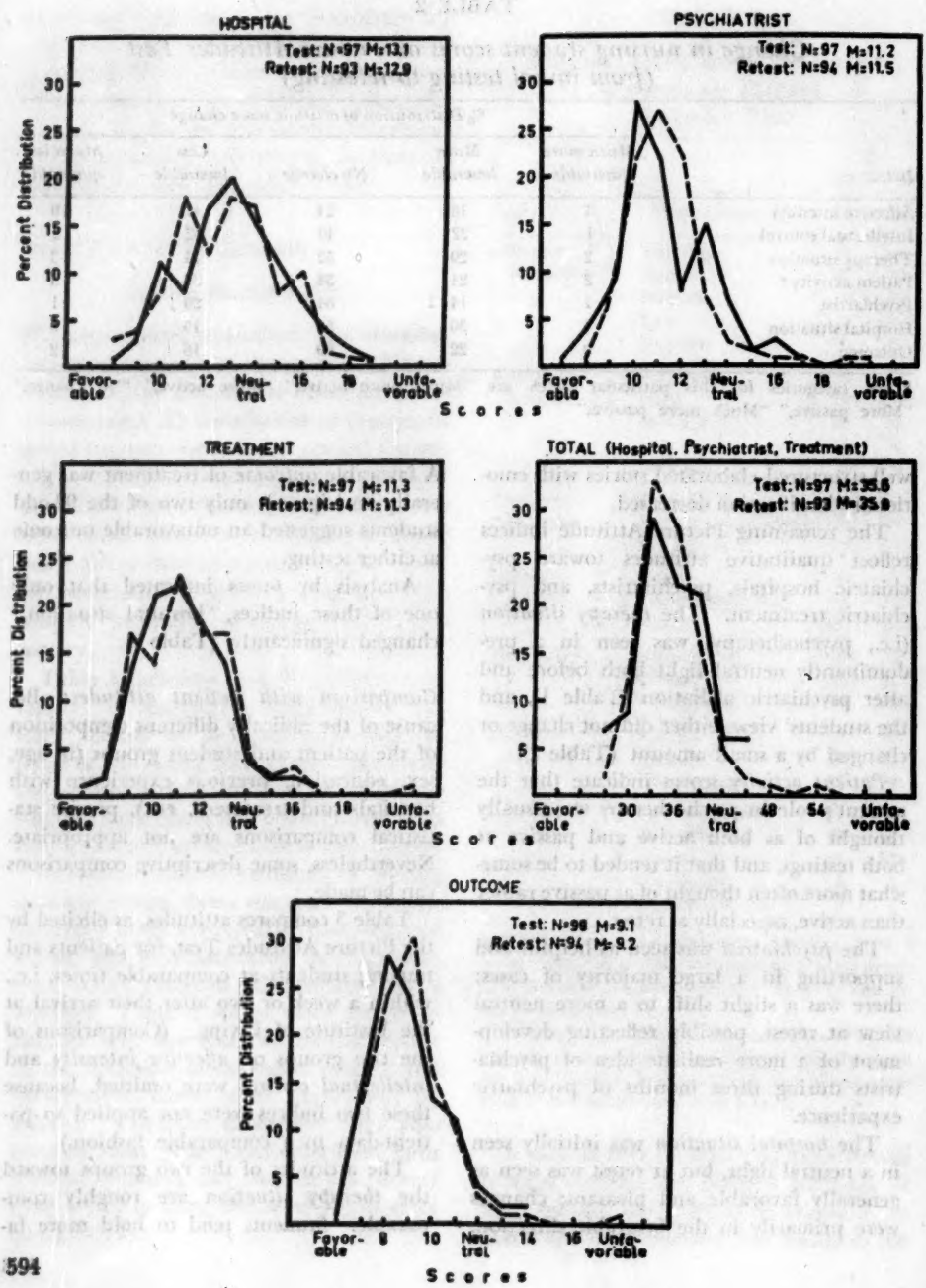

TABLE 3

Comparison of patient and nursing student scores on Picture Attitudes Test (initial testing)

Index	*Attitude score* *	% *Distribution* *Patients*	*Students*
Therapy situation	Pleasant	10	18
	Neutral or ambivalent	74	68
	Unpleasant	16	14
Patient activity	Active	42	16
	Active and passive	45	60
	Passive	15	24
Psychiatrist	Helpful	53	79
	Neutral	40	19
	Threatening	7	2
Hospital situation	Helpful	18	27
	Neutral	53	56
	Threatening	29	17
Outcome †	Very favorable	24	34
	Favorable	24	43
	Neutral	47	21
	Unfavorable	4	2
	Very unfavorable	1	0

* Scores are on a continuum, ranging from 1 to 3†, with a low score representing a more favorable attitude, and more affective intensity and intellectual control.

† The *Outcome* index was derived by summing the scores for both Picture Attitudes stories and hence ranges from 2 to 6 rather than from 1 to 3.

vorable attitudes regarding the *hospital situation* and the probable *outcome* of treatment, and are strikingly more favorable in their view of the *psychiatrist*, although patients, too, hold more favorable attitudes in this area than in such others as treatment and hospital situations. Interestingly, patients see the *patients' role* in psychotherapy as considerably more active than do nursing students.

The fact that strong differences were found in only two Sentence Completion indices (views of psychiatrists and of patient-role) suggested a functional relationship between these two attitudinal areas. It seemed possible that extremely positive views of psychiatrists might be based on a conception of them as omnipotent, magical healers, so that a view of the patient as entirely passive might be related to highly favorable attitudes toward psychiatrists.

As a rough check of this hypothesis, a 3 x 3 chi square test was done on students' combined test and retest data for these indices. A trend was revealed, but the relationship failed to reach significance.

Sentence Completion Test

Nursing student attitudes: The distribution of test and retest scores on the Sentence Completion Test is shown in Figure 1. The distribution of score changes is shown in Table 4.

Attitudes toward the *hospital* were slightly more favorable than unfavorable, both before and after psychiatric affiliation (Figure 1); changes showed a slight tendency to be more frequently in a favorable direction (Table 4).

Attitudes toward the *psychiatrist* and toward *treatment* were moderately favorable at both times (Figure 1), and changes were, to a very slight extent, more often in the unfavorable direction.

The *total* of these three indices revealed moderately favorable over-all attitudes at both times (Figure 1), and negligible mean change (Table 4). Expectation of *outcome* was moderately favorable (Figure 1), and changed little on the average (Table 4). None of the changes was significant (Table 9).

Attitudes, partially unconscious, elicited by the Sentence Completion Test differ in two ways from the even less-conscious atti-

FIGURE 2

PERCENTAGE DISTRIBUTION OF STUDENT AND PATIENT SCORES ON THE SENTENCE COMPLETION TEST (INTIAL TESTING)

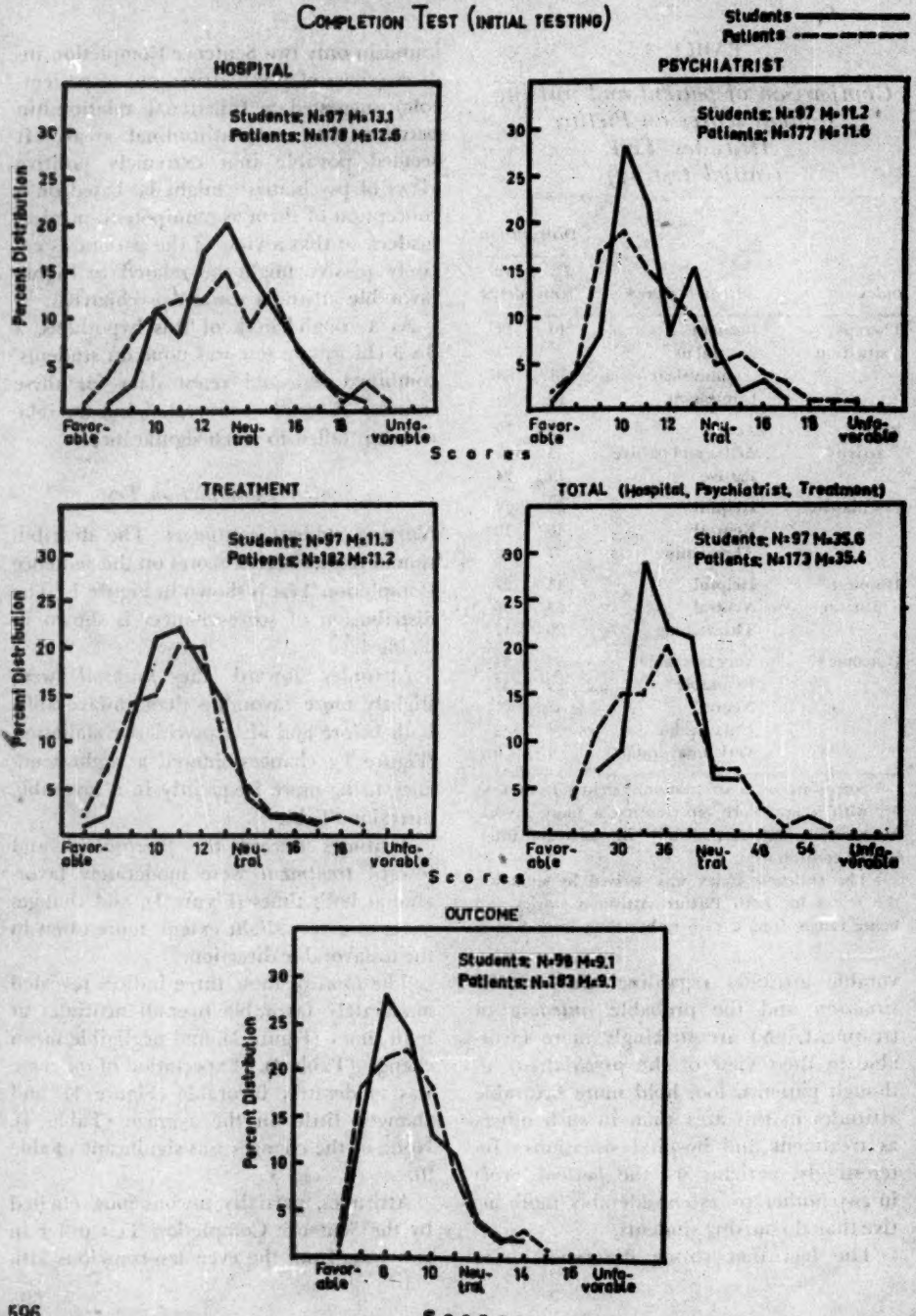

TABLE 4

Change in nursing student scores on Sentence Completion Test (from initial testing to retesting)

	% Distribution of attitude score change				
Index	*Much more favorable*	*More favorable*	*Negligible change*	*Less favorable*	*Much less favorable*
Hospital	3	32	35	29	1
Psychiatrist	4	18	51	23	4
Treatment	2	13	61	20	4
Total	2	17	63	15	3
Outcome	1	17	63	17	2

tudes revealed in the Picture Attitudes Test:

(A) Initially, students evidently have unconscious reservations about the *hospital situation*, which about balance with their favorable attitudes (Table 1) but which they do not reveal to as great an extent in Sentence Completion responses (Figure 1);

(B) Similarly, students seem, both before and after affiliation, to have unconscious unfavorable attitudes to *treatment* to about the same extent as favorable attitudes (Table 1) whereas on a more conscious level positive attitudes predominate (Figure 1).

In other areas, i.e., toward *psychiatrists* and *outcome* of treatment, attitudes elicited by the two techniques are comparable. The above noted differences may, on the other hand, result from the two techniques' referring to different aspects of the hospital and treatment situation. For instance, the patient-doctor picture is not likely to be perceived in any way except as a psychotherapy (or similar interview) situation, whereas the Sentence Completion "treatment" items are less structured and may be construed as referring to other aspects of the total hospital treatment plan.

Nevertheless, since a fairly common interpretation of these statements is in terms of the presumably unpleasant shock therapies, it is, on the face of it, rather unlikely that the more favorable Sentence Completion responses can be wholly accounted for on the basis of different content.

Comparison with patient attitudes: Figure 2 compares initial attitudes of nursing students with those of patients. The striking feature of the comparison is the quantitative similarity between students' and patients' attitudes. (The somewhat flatter, wider patient curves probably reflect the greater of the patient group heterogeneity.)

The inference is that initial attitudes to psychiatric hospitals, therapists, and treatment are not a function of age, sex, occupation, socioeconomic status, or degree of health. Such an inference is consistent with the findings of an earlier study (2) which established no relationship between overall attitudes and any "background factor," with the following exceptions: neurotic patients generally had more favorable attitudes than psychotics, and patients who had previously had psychiatric treatment of any kind had less favorable attitudes than those who had not.

Questionnaire

Nursing student attitudes: Table 5 shows distribution of test and retest scores on the

TABLE 5

Test and retest scores for nursing student on Multiple Choice Attitudes Questionnaire

Index	Attitude score *	% Distribution Test	Retest
Hospital	Favorable	81	82
	Neutral	19	18
	Unfavorable	0	0
Psychiatrist	Favorable	65	69
	Neutral	29	28
	Unfavorable	6	3
Treatment	Favorable	61	50
	Neutral	38	49
	Unfavorable	1	1
Total	Very favorable	40	30
	Moderately favorable	40	56
	Neutral	19	13
	Moderately unfavorable	1	1
	Very unfavorable	0	0

* Scores are on a continuum, ranging from 4 to 12 (12 to 36 for *Total*), with a low score representing more favorable attitudes.

Attitudes Questionnaire. Table 6 shows score changes.

The largely conscious Questionnaire technique elicited virtually no unfavorable attitudes among nursing students. *Hospitals* were seen in a highly favorable light both before and after affiliation; *psychiatrists* and *treatment* too were seen as predominantly favorable (Table 5) although attitudes about *treatment* shifted slightly in an unfavorable direction (Table 6).

Over-all attitudes, as reflected in the *total* score, were predominantly favorable (Table 5) and did not change on the average (Table 6). Table 9 indicates that no Questionnaire score changed significantly.

It was suggested above (in the section on the *Sentence Completion Test*) that procedures tapping more conscious ideas may be less effective in eliciting unfavorable attitudes. The overwhelmingly favorable attitudes expressed on the Questionnaire are consistent with such a hypothesis: the Questionnaire was constructed to assess even more conscious attitudes than the Sentence Completion Test. In other words, it appears that tests eliciting progressively more conscious attitudes are progressively less able to reveal any unfavorable attitudes.

Comparison with patient attitudes: Table 7 compares nursing student and patient Questionnaire scores at initial testing.

In general, patients have more extremely favorable attitudes than do nursing students on this largely conscious measure. This represents a reversal of the trend on the

TABLE 6

Change in nursing student scores on Attitudes Questionnaire (from initial testing to retesting)

Index	% Distribution of attitude score change: Much more favorable	More favorable	Negligible change	Less favorable	Much less favorable
Hospital	0	15	73	12	0
Psychiatrist	3	17	70	10	0
Treatment	0	9	69	22	0
Total	2	22	55	20	1

TABLE 7

Comparison of patient and nursing student scores on Attitudes Questionnaire (initial testing)

Index	Attitude score*	% Distribution: Patients	% Distribution: Students
Hospital	Favorable	73	81
	Neutral	24	19
	Unfavorable	3	0
Psychiatrist	Favorable	80	65
	Neutral	16	29
	Unfavorable	4	6
Treatment	Favorable	63	61
	Neutral	36	38
	Unfavorable	1	1
Total	Very favorable	55	40
	Moderately favorable	30	40
	Neutral	11	19
	Moderately unfavorable	3	1
	Very unfavorable	1	0

* Scores are on a continuum, ranging from 4 to 12 (12 to 36 for *Total*), with a low score representing more favorable attitudes.

Picture-Attitudes Test, which presumably taps far fewer conscious attitudes, and to which the patients' responses were generally less favorable.

Since the Questionnaire *is* obviously the most susceptible of the three measures to conscious control and "faking," it may be hypothesized that patients seize the opportunity to deny their stronger and more troublesome negative feelings about psychiatric matters and do so to a more marked degree than do nursing students.

Souelem Attitude Scale

Nursing students attitudes: Table 8 shows mean, standard deviation, and range of Souelem scores for students (test and retest) and patients (test), together with Souelem's patient norms. It is evident that no change took place in nursing student attitudes as measured by Souelem scores.

Comparison with patient attitudes: It can be seen that nursing student scores indicate slightly (but not significantly) more favorable attitudes than Institute patient scores, which in turn are slightly (but not significantly) more favorable than Souelem's VA and State hospital patient norms.

A comparison of variability is also of some interest. While the range of scores for all groups is roughly equivalent, students' scores tend to cluster around the mean considerably more than patient scores, Souelem's groups being most variable of all.

Comparison of Student and Patient Changes

Patient changes: Some information is available on changes in patient attitudes during psychiatric hospitalization. A previous study (7) reported on 30 patients whose attitudes were assessed within two weeks after admission to the Institute of Living, and reassessed after specified periods of

TABLE 8

Comparison of nursing student (test and retest) and patient (test) scores with norms *

	N	*M*	*SD*	*Range*
Nursing student				
Test	98	3.82	.50	3.0–7.3
Retest	93	3.80	.56	2.7–6.3
Patient test	177	4.26	.81	3.1–7.9
Souelem norms				
VA hospital	95	4.57	1.06	3.0–8.2
State hospital	103	4.46	.99	3.0–7.1

* (Souelem, 1955.)

time: 10 patients were retested after two months, 10 after four months, and 10 after six months. The average interval of about four months was thus roughly comparable to the three-month interval between student testings.

Apart from predetermining the time between test and retest, no other selection criteria were employed in choosing patients. Nevertheless, it was subsequently discovered that the three groups were different in certain respects from each other and from the larger unselected group whose initial attitudes had been assessed (1, 2). Because of these differences, and because of the small number of patients retested, only tentative comparisons can be made between patient and nursing student attitude changes.

From the four measures comprising the Psychiatric Attitudes Battery, 17 scoring indices for evaluating attitudinal change were derived.

Comparison of student and patient changes: In general, for all three patient groups, attitudes toward psychiatrists, treatment, and outcome became more positive; attitudes toward the psychiatric hospital underwent no change. In contrast, nursing students' attitudes toward the hospital were the only ones showing consistent changes in a favorable direction; students' attitudes in other areas generally became slightly (though insignificantly) less favorable.

That students' attitudes toward hospitals are particularly improved is the more striking in that their initial attitudes toward hospitals were relatively more favorable than patients, and patient data indicated that it was the less favorable initial attitudes that underwent the more marked positive changes.

This contrast between student and patient changes may be hypothesized to reflect the different emphasis in experience at the Institute: students are perhaps more oriented toward functioning in the general hospital setting, while patients are far more intimately involved with psychiatrists and psychiatric treatment and have a more personal interest in the outcome of treatment.

Patient data suggested that longer hospital stays were associated with increasingly great attitudinal shifts in the positive direction, implying that increasing experience and knowledge of psychiatric matters tend to improve attitudes toward them; it is reasonable to suppose that differential interests modify the effects of hospital experiences on attitudes.

One other patient change was noted: less intellectual control was exhibited in the Picture Attitudes scores at retest. The same tendency is present in nursing student stories. However, students also exhibited decreased emotional involvement in their stories, while patients did not, possibly because students were near the end of their hospital stay, and knew it, while patients were not necessarily ready to be discharged, and thus actually continued to be relatively strongly emotionally involved in hospitalization.

Patient data suggested that more conscious attitudes were more resistive to change: almost all the significant changes were reflected on the Picture Attitudes and Sentence Completion tests. A similar trend was noted in the nursing student data, although far fewer significant changes were established: all three of the significant changes were elicited by the Picture Attitudes Test (see Table 9).

Significant changes in nursing student attitudes

In order to assess the significance of changes in nursing students' attitudes toward psychiatric matters during psychi-

TABLE 9

Significant test-retest differences in nursing student attitude scores

Test	*Index*	*Significance*	*Interpretation*
Picture attitude	Affective intensity	$P < .01$	Affect decreased
	Intellectual control	$P < .02$	Intellectual control decreased
	Hospital situation	$P < .01$	Perception of hospital became more favorable
Sentence completion	(No significant changes.)		
Questionnaire	(No significant changes.)		
Souelem	(No significant changes.)		

atric affiliation, test-retest differences in attitude scores for the combined groups were analyzed by *t*-tests of the mean differences. Results are summarized in Table 9.

It will be seen that of the 17 test-retest indices, only three are significant. Of these, only one directly reflects shifts in attitude, i.e., a change in perception of the *hospital situation* (Picture Attitudes Test) to a more favorable one. It has already been commented that less-conscious attitudes, such as those tapped by the Picture Attitudes Test, reveal change more readily than more conscious attitudes, and that it was the area of attitudes toward hospitals that seemed to have the most valence for nursing students. It is consistent to suppose that these two factors combined to bring about a significant change in this index.

The other two significant test-retest differences reflect changes in the form and content of stories elicited by the Picture Attitudes Test, i.e., less affect is expressed, and stories reflect less intellectual control. While these changes suggest increasingly unfavorable attitudes, it has been suggested that such shifts are largely a reflection of a change in the test-taking situation itself, related to the fact that the students were nearing the end of their affiliation, and thus had sharply decreased interest or emotional involvement in their test productions.

SUMMARY

This study was designed to explore one facet of the attitudinal atmosphere prevailing in a private mental hospital. Whereas previous studies by the authors and their associates have investigated patient attitudes and their implications for successful treatment, the present study examined attitudes of service personnel. Affiliating nursing students, specifically, were chosen for study because of their close, if transient, contact with patients, their availability for assessment as a group, and the relative homogeneity of the group.

Attitudes toward psychiatric hospitals, psychiatrist, and psychiatric treatment were assessed by means of the Psychiatric Attitudes Battery at the beginning and again at the end of the students' three-month affiliation. The pattern of attitudes at each testing, as well as the changes between testings, have been described for each of the four tests comprising the battery, and for each general area of attitudes.

While marked group differences made precise statistical comparisons inappropriate, descriptive comparisons were also made between students and a previously studied group of patients on initial attitudes, and some tentative comparisons were ventured between students and a small group of patients on retest indices of attitude and on

attitude change. Some tentative interpretations of the patterns of data were indicated; hopefully these ideas may serve to suggest further research. A formal statistical approach was utilized in assessing the significance of nursing student attitude changes; three of seventeen test indices changed significantly.

Although specific findings of this exploratory study were far too complex to summarize in detail, two over-all trends stand out rather clearly. First, patient attitudes toward psychiatrists, psychiatric treatment, and outcome of treatment tended to become more positive during hospitalization, while their attitudes toward psychiatric hospitals remained essentially unchanged. In contrast, student attitudes toward hospitals shifted in a more favorable direction, and their other attitudes became slightly (though insignificantly) less favorable. This contrast has been interpreted in terms of the different emphasis and personal meaning of hospital experiences of the two groups.

Second, patient's attitudes were generally less favorable than students' on measures of largely "unconscious" attitudes, and more favorable on measures of most "conscious" attitudes. This difference has been assumed to imply that patients have stronger and more distressing underlying negative feelings about psychiatric matters, which are elicited by "projective" tests, and which they, more than students, need to deny on a conscious level.

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HERBERT A. OTTO, PH.D.

The school administrator's mental health

Over the past decade there has been a slowly increasing recognition that the school administrator is a key factor in determining the type of atmosphere and climate prevailing in a school or school system.

However, an examination of inservice training programs for school administrators and programs of professional meetings reveals that very little program time is devoted to a consideration of the school administrator's role in relation to the mental health of the school or school system. Almost nonexistent are programs or program time devoted to examining the principles, factors or forces which may be useful in strengthening the mental health of the school administrator.

References in some of the standard texts on school administration (1, 2) and a number of studies (3, 4) indicate that there is a growing awareness of the role of the school administrator vis-à-vis the emotional climate of a school or school system. For example, Jenkins and Blackman in their study of *Antecedents and Effects of Administrative Behavior* state that "Atmosphere is the kind of emotional climate that surrounds the group operation. Inasmuch as the administrator has an important position in the school, he is very likely to have a predominant effect on the emotional environment in which the teachers work" (1).

The school administrator's influence on the emotional climate of the school is often pervasive but little understood in terms of its total impact. For example, if the administrator has had a "bad day" or is under considerable tension, nervous and irritable, "feeling low" or short-tempered, this often has immediate and far-reaching repercussions. Some of the teachers and school personnel are aware how the adminstrator

Dr. Otto was formerly assistant professor of mental health, College of Education, The University of Georgia, Athens, Ga. He is now associate professor, Graduate School of Social Work, University of Utah, Salt Lake City.

feels, often early in the morning. They sense his shortness and irritability and this in turn causes them to be tense.

By noon the effects are noticeable over a considerable portion of the school, and by the time school closes practically every staff member knows that this has been an "off day." Inevitably classrooms are affected. Many times there are classroom disturbances with no seeming cause which make teachers remark at breaktime in the faculty lounge: "I wonder what got into them today?" In the majority of instances, neither the school administrator nor the staff knows the origin of such student behavior or why this particular day left everyone with the feeling of disturbance.

Both school administrator and staff often have difficulty in seeing that a cause/effect relationship may exist between the administrator's mental healthiness and the prevailing climate of the school. During a recent conference on school mental health, a consultant from the National Institute of Mental Health was asked about the importance of the school administrator's mental health.

He replied: "This reminds me of the question 'Is the teacher's mental health more important or that of the children?' My answer always is: 'The teacher's.' The teacher's mental health status has a great deal to do with the mental healthiness of the students. The administrator's mental health is *the* most important because his state of mental healthiness influences the teachers and staff and through them, the students."

No studies exist to determine in what ways and by what means school administrators attempt to cope with the stresses, strains and tensions which are an integral part of their professional setting. In the course of developing a mental health program in a teacher training institution (5) the writer did considerable consultatory work with school administrators. School mental health consulation services to administrators were extended as a part of ongoing inservice training programs for teachers and on the basis of individual requests for such services. Conferences with school administrators were conducted in connection with classes, workshops or professional meetings usually held on the campus of the University of Georgia

It was noticed that in the majority of individual or group conferences with school administrators, questions and discussions would first focus on the tensions or pressures which administrators felt were present in their professional environment. This was invariably followed by remarks or comments indicating that administrators felt a need to foster or improve their mental health. Usually this was expressed through humorous or jocular references such as: "I need more mental health but how can I get it? I guess I need a psychiatrist . . ." (general laughter). Or, "Yes, I know all these pressures are not good for my mental health, but if I am going to stay with the job I'll have to learn to live with them. You tell me how . . ." (laughter).

The persistent emphasis on the topic "What can be done to improve the mental health of the school administrator?" suggested a survey-type study to explore what practices school administrators believe have had a positive or strengthening effect on their mental health. Consequently, whenever the opportunity arose—either in individual conferences or as a part of group discussions—over a five-year period, the following question was routinely posed and the results recorded: "What practices have you used or what things have you done which you believe have improved your mental health?"

This question not only produced specific

answers but was often followed by spontaneous group discussion after the responses had been listed. The writer kept notes on the group discussions and recommendations and this data is used for this present study. A total of 321 responses were recorded over a five-year period. Responses were contributed by 137 Georgia school administrators either in a group setting (inservice training activities and workshops or college classes) or during individual conferences (consultation). The responses can be summarized as follows:

Practices Which School Administrators Believed Improved Their Mental Health	*Number of responses*	*Per cent of responses*
1. Talking it out or talking it over	86	26.7
2. Developing good administrative working relationships	81	25.3
3. Handling work pressures, routines and office atmosphere	57	17.8
4. Securing a balanced life outside of the office	48	14.9
5. Others	26	8.1
6. Improving communication and listening	23	7.2
	351	100

An analysis and discussion of each group of responses is presented and some of the outcomes, conclusions and recommendations from the various group discussions will be given in summary form.

TALKING IT OUT OR TALKING IT OVER

Slightly over one-fourth of all recorded responses fell into this grouping. One school administrator described the mental hygiene value of "talking it over" or "talking it out" as follows:

> "If I don't talk it out, I am too full of what happened and how I feel about it to get a constructive perspective. My emotions take over. If I let this emotional complex sit, I know I have got to wait for a while before I act. When I talk it out I can usually act much more quickly because I get my good judgment back as I talk."

The words "getting it off your chest," "blowing off steam" and "getting it out of your system" were often used to describe this process.

Although a significant percentage of school administrators seem to be convinced of the prophylactic properties of "talking things out," analysis of the records brought to light an interesting fact. The large number of responses in this category was traceable in part to the recognition by school administrators (usually in the course of group discussion) that they had been using this principle, although not consistently and often without being consciously aware that it had anything to do with mental health. This is illustrated by the following remarks:

> "I do this every now and then but not often enough." "I have been doing this off and on for years but mostly when absolutely driven by pressures and circumstances. I never thought of doing it consistently as a method of dealing with pressures."
>
> "When I couldn't take the tension, I talked things out. I know I ought to use this before the tensions get that high."

Some administrators suggested that selection of appropriate office personnel would facilitate use of this principle. In many group discussions the statement was made that the most desirable type of secretary should have qualities of understanding and *the ability to listen* as well as proficiency in clerical skills. One administrator said "I've got me a good secretary. She lets me blow up and listens to me and doesn't take it personally."

Other administrators called in members of the teaching staff with whom they had close relationships and talked over certain problems with them. Wives were described as often "being good listeners," although the general conclusion was to solve problems on the spot if at all possible and not to "take them home."

DEVELOPING GOOD ADMINISTRATIVE WORKING RELATIONSHIPS

An almost equally large group of responses (one-fourth of the total) gave an indication that establishment of good working relations with superiors and school personnel fostered mental healthiness. This seemed to be an area fraught with some anxiety and tension, as in the majority of group discussions cases of inadequate working relations with superiors as well as colleagues were brought to light. In many instances discussion led to considerable self-revelatory sharing of past experience, often dating back to the early working history of the administrator. Self-revelatory remarks were often in a humorous vein and accompanied by much laughter. On many occasions principals and superintendents related experiences with school administrators while they were still staff members and had not been engaged in administrative work. These incidents and case histories were almost invariably illustrative of harmful or hurtful administrative-staff relations and represented affectively charged experiences for the school administrator involved. Invariably, lack of good working relations with school personnel and superiors was identified as a mental health hazard.

Repeatedly school administrators would make remarks indicating that developing good working relations with school personnel (and colleagues) had made a major contribution to their mental health. For example, the principal of a grade school made the following comments:

> "The best thing I have done for my mental health was to work on what I call creating the best possible working atmosphere. A committee and I worked on this for the first three months of the school year and I now have the best working relations with my teachers I have ever had."

The superintendent of a large school system made this observation:

> "One day I sat down and took a hard look at my way of working with administrative and school personnel. This had been bothering me for some time and I hadn't been able to sleep well, so you can see my mental health was affected. I decided this had to be a team working together and I must be a member of the team. I have been hitting that theme ever since and it has not been a bed of roses. But for the first time in 15 years as superintendent I am not losing any sleep over this problem. I can see an improvement from month to month. This has improved my mental health more than anything else I have done."

A good working relationship with superiors was often described as one which was considered by both parties as productive and satisfactory and that this relationship had close similarities to the educational process, with learning taking place on both sides. Surprisingly, a number of administrators underscored the fact that even an unsatisfactory relationship with an administrative superior can be used positively and can become a source of strength and growth.

> *Principal A:*
> "My superintendent makes decisions for me and I sometimes end up in left field as a result but I continue to believe that people can change, even at his age. I have been working on him and with him for years. It is slow work, like the raindrop on the stone. When I look back where he started, I realize we have come a long way. I get some satisfaction from this."

> *Principal B:*
> "I look at what my superintendent does, take what he does, turn it around and look at myself. For example, he makes all decisions, even many he knows should be up to me. I used to make more decisions for my teachers than I should have. This has stopped. He never gives me or anyone else any recognition or praise. I began giving all the deserved recognition and praise I could possibly give to all my staff. This has transformed the school; it's also done wonders for my mental health."

Another area in which there was evidence of considerable emotional involvement centered around the matter of presenting con-

troversial issues to the superior. Generally, there was a consensus that a "straight from the shoulder" approach was favored as a means of respecting and recognizing the integrity of both administrator and superior. One administrator said:

> "I always present my point of view, or the way I see an issue, to him straight and clear-cut, no matter how unpleasant. He may not like me or what I have to say at the time but sometime later he has always respected me for it. Under these circumstances I maintain my integrity and at the same time I appeal to his integrity. I am saying to him: 'he has it; he can exercise it,' and he does."

There was general agreement that it is possible to build the type of relationship in which both parties feel free to differ with each other over controversial issues. A minority of administrators maintained that it should be possible at times to become sufficiently involved over an issue to differ strongly. One superintendent remarked:

> "I have the best working relations with the men who can argue with me. We may raise our voices and disagree but we respect each other and each other's judgment."

The "straight from the shoulder" approach was contrasted with the so-called "diplomatic" approach. The essential element of the "diplomatic" approach seems to be an inner feeling of conviction or certainty of the soundness of the particular judgment or view of a controversial issue held by the administrator which stands in opposition to that known to be held by his superior. As a consequence the administrator withholds his conviction or even agrees with the superior, although he inwardly rejects this superior's views and attitudes. One principal remarked:

> "Mr. S., my superior, has certain things he believes in which I don't believe. No amount of what I can say is going to change that. I keep quiet and think my own thoughts, but I can't say I like it."

There was consensus that although most administrators use the "diplomatic" approach at times, this approach was essentially detrimental to the self-respect and self-esteem of the user and in this way adversely affected mental health.

Good administrative relationships with school personnel and superiors seem to emerge best as a consequence of working together on a problem. There was also general agreement that good working relations with colleagues and superiors must never be taken for granted, but that it takes continued effort to maintain and improve them. It was recognized that the very process of working on the improvement of administrative relationships can have mental health values for the administrator who is consciously engaged in this process and who has "thought through" this problem.

WORK PRESSURES, ROUTINES AND ATMOSPHERE

The third largest group of responses (17 per cent) indicated that certain ways and means of dealing with work pressures, routines and office atmosphere improved the mental health of the administrator. The outstanding finding here was that the nature of the work pressures rather than the work pressures themselves were seen as having a relationship to mental health.

It became evident that not only is the school administrator faced with many demanding routine administrative tasks, but at the same time he is in a position to be continuously interrupted in order to deal with human relations problems of a considerable complexity and magnitude. Teachers, students and parents call on him throughout the day. The demanding nature of these human relations problems often make inroads on the emotional reserves of the administrator. This induces an emotional state or feeling of "being

drained" or depleted at the end of the work day. In other words, the administrator feels that he has given of his emotional resources but has had very little "coming in."

This confronts the administrator with the task of finding the resources in his environment (or within himself) which will provide him with the warmth of understanding and the emotional support he needs.

There was consensus among administrators that a direct relationship seems to exist in the administrator's ability to provide this type of inflow and his capacity for handling work pressures Administrators also pointed out that all too often understanding colleagues—staff members as well as parents —were untapped resources

In a number of group discussions school administrators reached the conclusion that giving of understanding is a two-way process through which both the staff member or parent as well as the administrator can grow.

"For a long time when parents came to my office I saw them coming for advice from me and I gave it to them. This was false. I learned from them and they learned from me. We do it together. They give something to me and I give something to them."

Toward the end of a group discussion one administrator concluded:

"There are a number of warm and understanding persons in most school faculties. I think we should find out who these people are, cultivate them, discuss our problems with them. They have something to give to us and we have something to offer them. We should call on them and invite them to help us. After all, a school isn't run by the principal but by everyone in it."

It was recognized that many administrators have a tendency to postpone unpleasant tasks. This in turn creates tension, guilt and "last minute gallop," a strenuous and taxing effort to get the work done just before the deadline. Those administrators who had been able to break themselves of the "last minute gallop" habit reported a considerable lessening of tensions and an increased capacity for enjoying life and work. ("I don't have the nagging feeling that the next work crisis is just around the corner.")

Administrators admitted that it took a major crisis to stop the habit once it had become a routine mode of working.

"It took just one little heart attack to change my working habits."

"One time I worked all night and sent in the worst job you have ever seen. It cured me in a hurry."

There was some consensus that a properly trained, highly competent secretary who could relieve the administrator of routine tasks is the most effective single way of dealing with work pressures. A "depth approach" was recommended to achieve the best possible management of work pressures. It was suggested that in the course of a series of school system-wide workshops or institutes, administrators could concentrate in depth on the underlying feelings and attitudes related to work pressures, work patterns and work habits. One administrator made the following significant statement:

"I would vant one institute only for principals, another one only for superintendents. I would be afraid for my boss to know about my work habits. We are all supposed to have a high degree of professional competency."

This idealized professional image of the principal or superintendent—as being so proficient he very rarely makes any mistakes —creates a block to personal and professional growth. Unless the person in a position of administrative leadership takes concrete steps to deal with this block, his

subordinates may conclude that problems or mistakes must not be brought to the attention of their superior. This produces a stifling environment where the subordinate feels isolated. If he were to ask his superior for help with a problem, this would indicate he was lacking in professional competency. There were definite indications that many administrators were operating in settings where they did not have the freedom to ask their superiors for help when errors in judgment had been made.

The office atmosphere was seen as having an effect on the mental health of the administrator. Again, the emphasis was on the selection of office personnel who were friendly, warm and outgoing persons and who *thereby* created a relaxed and friendly atmosphere, coupled with efficiency and productivity. One superintendent said:

> "The first thing I did when I got into the office was to retire two of the old clerks in the front office and replace them with the best products of our business school. I personally selected the friendliest and most efficient girls I could find. The effect on me and everyone else was magic. The girls made everyone coming into the office feel welcome."

Transformation of certain physical aspects of the office environment was seen as having a psychological effect. Air conditioning was cited as inducing a feeling of well-being and improving efficiency and thereby improving mental health. Several principals and superintendents used a rotating selection of student art to brighten their offices. Some administrators encouraged office help and school personnel to grow potted plants and flowers. A number of school administrators also conducted a joint study with their office staff to effect a more comfortable and efficient placement of office furniture. The conclusion was that the arrangement of the office furniture could change the atmosphere of the office.

It was apparent that a considerable range of ideas, principles and procedures is at the disposal of the administrator who realizes that improvements in work pressures, office routine and atmosphere can affect his mental health. There is every indication that this area offers many productive opportunities which can bring immediate and often far-reaching results extending not only to the administrator but also to the school or school system.

A BALANCED LIFE OUTSIDE OF THE OFFICE

The fourth largest number of responses (15 per cent) fell under this heading. This relatively large number of responses seemed to reflect the recognition by school administrators that persons in leadership position are "overorganized." They belong to too many organizations and their professional responsibilities increasingly encroach on their family lives and recreational pursuits. Often this is a gradual process so that many administrators are not aware of the extent to which their private lives and recreational and leisure-time have been curtailed.

Analysis of responses indicates that at some period in their professional lives an approximately equal number of administrators recognized that they were not spending enough time with their families or that they did not have sufficient leisure-time for relaxation and recreation. These administrators then took concrete steps to remedy this situation and reported a consequent lifting in morale and an improvement in mental health. One superintendent described this experience as follows:

> "I didn't know what was wrong with me—I was always tense and tired. I must have belonged to more than a dozen civic and fraternal organizations not counting professional groups. I was active in all of them.

"One night when I worked late and went to a dinner meeting I suddenly realized I hadn't seen my family for the better part of the week. For the first time I really saw the full evenings in my schedule. I decided my trouble was that my professional life had taken over my home life. I called my wife and we had a long talk and went over the organizations and my schedule together and I now have sufficient evenings at home. The time I spend with my family does more for my mental health than anything else."

A principal of a large city high school made these remarks:

"I was so involved in civic groups, speeches and committee work that most of my evenings were full. When they weren't full, I took work home. The best thing I ever did for my mental health was to wake up and see what was going on. I now deliberately schedule time for recreation and take my boys fishing."

There was general agreement that a school administrator must expect that his work is "never done" and that after office work and commitments are a part of the profession. At the same time there was recognition of the fact that administrators have a tendency to overload themselves with such obligations to the detriment of their effective functioning. For these reasons it was recommended that a periodic (quarterly) review of this area be undertaken.

IMPROVING COMMUNICATION AND LISTENING

Successful efforts to improve communication between administrators and staff were cited as having a positive effect on mental health. Group discussions revealed that although a considerable number of administrators were aware of a need to improve communication and listening skills, only a small percentage had taken any concrete steps to remedy the situation. Administrators were largely in agreement that it would be desirable to have the type of atmosphere where staff members feel free to "drop in" to share with the administrator their concerns, observations and accomplishments.

"At first I required appointments. Then I thought this through and decided to have 'open house.' I found I had to change my attitude and be really glad to see people regardless of what I was doing. If it was something I couldn't put off, I tried to make them feel that even though I had to get the report done, they were more important and that I wanted them to come back. At first I used to serve coffee as an icebreaker. This is no longer necessary. There is a totally new spirit in our school as a result."

Improvement in communications begins with a re-examination and change in attitude and habit patterns of the administrator. Many ways and means to improve communication were found to be available. Some administrators discovered they could mimeograph up to 75 per cent of the business which had formerly occupied their staff meetings. Advance distribution of such a bulletin left considerable meeting time to be spent on productive discussion centered on areas of vital concern to school personnel and administrator alike.

Suggestion boxes for staff, coffee breaks in staff meetings and small group discussions within the staff meeting were some of the means employed to improve communication. A number of administrators discovered the prophylactic value of listening. Becoming a good listener seemed to give them a feeling of being able to understand people better.

"After I read a book on listening I was convinced that I had talked too much and was one of those 'high verbalizers.' It was slow at first, but then I began to hear things I had never heard before. My skill in understanding my staff increased—not to mention parents and board members. I have become a better administrator and am more interested in people and their problems."

Administrators agreed that it was not sufficient to merely read books on communi-

cation and listening but that a different set of attitudes had to be developed. The recommendation was made repeatedly that the area of communication and listening skills should be included in inservice training programs for administrators as well as in institutes and workshops conducted for the purpose of training administrators.

DISCUSSION

The number of responses (86) under the heading "Talking it Out or Talking it Over" was larger than the number of responses classified under "Developing Good Administrative Working Relationships." Since the writer usually gave a short talk on school mental health (including a discussion of mental health principles) preceding the presentation of the survey question to the group, it is possible that the larger number of responses under "Talking it Out or Talking it Over" is, in part at least, traceable to the content of the lecture-type presentation. It can be assumed that because "Talking it Out" was identified in the presentation as having mental hygiene value, a number of school administrators recognized that they had been using this principle without identifying it as having implications in terms of their mental health.

If this assumption is correct, then the large number of responses under the second group "Developing Good Administrative Working Relationships" becomes even more significant. Perhaps this group would have ranked first by number of responses had the survey question not been preceded by a lecture or address which had reference to the practices outlined in group one. On the other hand, principles of "improving lines of communication" and "acquiring added skills in listening" were also mentioned during the lecture-type presentation and received a relatively low number of responses.

It is of interest to note that the first two groupings accounted for a total of 52 per cent of all recorded responses, whereas the next two largest groups—"Handling Work Pressures, Routines and Office Atmosphere" and "Securing a Balanced Life Outside of the Office"—make up 32.7 per cent of the responses. This seems to point to a broad pattern: namely, that two main practices ("Talking it Out" and "Developing Good Working Relationships") were used by a significant percentage of school administrators and were felt to have a positive effect on their mental health.

Repeated recommendations by administrators suggest the need for preservice and inservice training especially in reference to deeply established work habits and in relation to acquiring increased skills in communication and listening. A "depth approach" in terms of working with underlying attitudes was suggested in both instances.

SUMMARY

Over the past decade there has been an increasing awareness of the key role of the school administrator vis-à-vis the emotional climate and atmosphere of a school or school system. However, very little program time at professional meetings or in inservice training programs is being devoted to an examination of the school administrator's role in relation to the mental health of the school or school system. Programs or program time spent on examining the principles, factors or forces which may be useful in strengthening the mental health of the school administrator are almost nonexistent.

As a part of a "Mental Health Program in a Teacher-Training Institution," con-

sultation services were extended to school principals in the field as well as to groups of administrators attending professional meetings or engaged in preservice training course sequences and inservice training programs.

It was noted that in discussions about school mental health a pattern emerged —school administrators tended first to talk about pressures or "mental health hazards" to which they felt they were exposed. Next, administrators would make comments or remarks (often in a humorous vein) indicating they felt a need to take concrete steps to improve their mental health.

This suggested a study to determine what specific principles or practices school administrators had used which they perceived as having had a positive effect on their mental health. This study, conducted over a five-year period, revealed that 137 Georgia school administrators used a variety of practices which they reported as having improved their mental health:

1. "Talking it out and talking it over" was used most frequently (26.7 per cent of total responses).
2. "Developing good administrative working relationships" was reported as being used with almost equivalent frequency as the above (25.3 per cent of the total responses).
3. "Handling work pressures, routines and office atmosphere" was next, with 17.8 per cent of responses.
4. "Securing a balanced life outside of the office" accounted for 14.9 per cent of the responses.

It is hoped this modest study will stimulate further investigation of principles and practices which may be useful in enlarging the mental health and emotional well-being of the school administrator. Perhaps this study can also make a contribution in the sense that time in inservice and preservice training programs will be devoted to an examination of the key role of the school administrator in relation to the emotional climate of the school.

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3. Jenkins, David H. and Charles A. Blackmap, *Antecedents and Effects of Administrator Behavior* (Columbus, Ohio: Ohio State University Press, 1956), 11.

4. Ramseyer, John Alvin, *Factors Affecting Educational Administration* (Columbus, Ohio: Ohio State University Press, 1955), 82.

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HENRY WECHSLER, PH.D.

Patterns of membership in a self-help organization in mental health

A number of sociological studies in recent years have been concerned with the general topic of the voluntary community organization, and specifically with the personal characteristics of individuals who join such groups.

Wirth was among the first to note the growth of voluntary associations. He attributed the growth of such associations to the loosening of traditional family bonds in an urbanized society: "Being reduced to a state of virtual impotence as an individual, the urbanite is bound to exert himself by joining with others of similar interest into organized groups to obtain his ends. This results in the enormous multiplication of voluntary organizations . . ." [1]

Rose [2] appears to be in basic agreement with this proposition when he reflects that voluntary associations fulfill the needs of self-expression and social influence which had been satisfied before urbanization by the community, church and family.

If individuals limited by the availability of necessary interpersonal relationships in the home and community are viewed as potential joiners of voluntary community

Dr. Wechsler is a research psychologist at the Massachusetts Mental Health Center in Boston and research associate in psychology in the Department of Psychiatry at Harvard Medical School, Boston, Mass.

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[1] Wirth, L., "Urbanism as a Way of Life," *American Journal of Sociology*, 44(July, 1938), 1-24 (p. 22).

[2] Rose, A. M., *Theory and Method in the Social Sciences* (Minneapolis: University of Minnesota Press, 1954).

organizations, it should not be surprising that in the past decade former mental patients have been joining together in ex-patient groups. Such ex-patient groups, or self-help organizations in the mental health field, may be characterized as associations of individuals currently residing in the community, who at some time have been afflicted with some form of psychiatric disorder and who meet together to provide and obtain mutual help.

A recent survey obtained information about the existence of 42 such organizations, 76 per cent of which have been established since 1951. Although self-help organizations in the mental health field have greatly specialized goals and are composed of a highly selective segment of the general population, most of them meet the specifications which have usually been associated with voluntary community organizations.[3] Such organizations usually have a formal structure, with a constitution and elected officers. Membership is on a voluntary basis, with the stipulation that members be persons who have received prior treatment for psychiatric difficulties or who perceive themselves to be in need of some form of help. In addition, such self-help organizations are private, as distinguished from governmental agencies, and are usually run on a nonprofit basis.

SELECTIVITY OF MEMBERSHIP

Although the number of ex-patient groups has increased at a rapid rate in the past decade, total membership in such organizations may be estimated at less than 5,000. In comparison to the growth of Alcoholics Anonymous, which estimates a membership of over 150,000,[4] the growth of clubs of former mental patients may be viewed as small.

Palmer[5] has discussed several deterrents to the growth of ex-patient organizations. She feels that the stigma associated with mental illness, the desire of many ex-patients to forget about their hospitalization, and the relative heterogeneity of psychiatric patients as compared to alcoholics are factors serving to limit the growth of social clubs for former mental patients.

Although these factors may serve to limit the size of the membership, another previously unconsidered explanation may be equally important: namely, that *only certain kinds of ex-patients will join such groups just as only certain kinds of individuals will join voluntary community organizations.* If the self-help organization in the mental health field is viewed as a special case of the community association, it may be that the same selective factors operating in relation to the joining of community associations in general are present in this special case.

A number of studies conducted in various communities have analyzed the personal characteristics of joiners of voluntary civic, fraternal, social and religious associations. The results have uncovered a surprisingly consistent series of differences between joiners and nonjoiners, despite the vast dissimilarity among the communities under study. In general, the following major trends have been indicated by the results:

A. *Membership is directly related to socio-economic status.* A number of studies have associated membership in voluntary community organizations to such indices

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[3] Axelrod, M., "Urban Structure and Social Participation," *American Sociological Review,* 21(February, 1956), 13–18.

[4] *Is A.A. For You?* (New York: A. A. Publishing, Inc., 1956). A pamphlet.

[5] Palmer, Mary B., "Social Rehabilitation for Mental Patients" *Mental Hygiene,* 42(January, 1958), 24–28.

of social class position as education, income and occupation.[6, 7, 8, 9, 10] Joiners have been found to have attained a higher level of education, to be employed more frequently in nonmanual occupations, and to have higher family incomes than nonjoiners.

B. *Membership is associated with religous preference.* Protestant persons have been found to join voluntary community organizations more frequently than Catholic persons.[11, 12] In addition, one study has concluded that Jewish persons are more frequent joiners than Protestant persons.[13]

C. *Membership is associated with family status.* Married persons have been found to join voluntary community organizations more frequently than single individuals.[14] Married persons with children have been found to join more frequently than married persons without children.[15, 16] However, the exact nature of the relationship between the number of children and the extent of participation may not be simple. Scott found that persons with two children are the most frequent joiners, persons with one child the least frequent, and persons with no children have participation rates somewhere in between.[17]

D. *Membership is associated with age.* Several studies have related age to extent of participation. Freedman and Axelrod[18] found that persons in their forties are the most frequent joiners, while Scott[19] found persons of 40 to 54 to be the most frequent joiners.

E. *Membership is associated with sex.* Men have been found to join voluntary community organizations more frequently than women.[20, 21] However, Scott[22] found that, whereas men join fraternal organizations more frequently, women join religous and church groups and betterment organizations more frequently.

THE STUDY

To test whether these same selective factors operate in regard to self-help organizations in the mental health field, information obtained in a study of Recovery, Incorporated, was used.[23] Recovery, Inc., is the largest and probably the oldest of these groups in the mental health field. It has 1,800 dues-paying members and, by its estimate, a total membership of over 4,000. Recovery was founded in 1937 and is incorporated under the laws of Illinois as a nonprofit organization. It is established on

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6 Axelrod, *op. cit.*

7 Freedman, R. and M. Axelrod, "Who Belongs to What in a Great Metropolis?" *Adult Leadership*, 1(November, 1952), 6–10.

8 Scott, J. C., Jr., "Membership and Participation in Voluntary Associations," *American Sociological Review*, 22(June, 1957), 315–26.

9 Wright, C. R. and H. H. Hyman, "Voluntary Association Memberships of American Adults," *American Sociological Review*, 23(June, 1958), 284–94.

10 Freeman, H. E., E. Novak and L. G. Reeder, "Correlates of Membership in Voluntary Associations," *American Sociological Review*, 22(October, 1957), 528–33.

11 Scott, J. C., *op. cit.*

12 Wright, C. R. and H. H. Hyman, *op. cit.*

13 *Ibid.*

14 Scott, J. C., *op. cit.*

15 *Ibid.*

16 Wright, C. R. and H. H. Hyman, *op. cit.*

17 Scott, J. C., *op. cit.*

18 Freedman, R. and M. Axelrod, *op. cit.*

19 Scott, J. C., *op. cit.*

20 Freedman, R. and M. Axelrod, *op. cit.*

21 Scott, J. C., *op. cit.*

22 *Ibid.*

23 For a detailed analysis of this organization the reader is referred to Wechsler, H., "The Self-Help Organization in the Mental Health Field: Recovery, Incorporated, A Case Study," *Journal of Nervous and Mental Disease*, 130(April, 1960), 297–314.

a national basis with local groups in 20 states. The organization employs a particular method of self-help and aftercare which was devised by its founder, A. A. Low.[24] Membership in Recovery, Inc., is open to all persons who have been hospitalized for mental illness and/or who perceive themselves to be emotionally disturbed.

Information was obtained on a large sample of Recovery members through the use of mailed questionnaires. A total of 1,875 questionnaires were sent to the headquarters of the organization and were then distributed in the state of Michigan, since that region contains almost 50 per cent of the total Recovery membership; 450 were sent to the greater Chicago area; and 75 were distributed to members in other states. Seven hundred seventy-nine questionnaires were completed and returned, providing a rate of response of 41 per cent.

The responses of the members were analyzed in order to answer three major types of questions:

I. A Comparison of the Selected Personal Characteristics of the Respondents and Residents of Their Home Communities

Are the members similar to or different from the other residents in their home communities? If any differences exist between the Recovery group and the general population, are these differences the ones that would be expected between a group of joiners and the general population?

II. Membership Patterns of Respondents

Do the Recovery members belong to other voluntary community organizations or is their participation limited only to Recovery, Inc.? Do they belong to fewer or more voluntary community organizations than do the residents of their home areas?

III. Relationship of Extent of Participation in Voluntary Community Organizations to Selected Personal Characteristics of Respondents

Do Recovery members with extensive participation in other voluntary community organizations differ from members with little or no such participation? Are these differences of the same nature that would be expected between joiners and nonjoiners?

RESULTS

I. A Comparison of Selected Personal Characteristics of the Respondents and Residents of Their Home Communities

Since nearly all the questionnaires were sent to Recovery members in Michigan and Illinois, the personal characteristics of the respondents were compared to the U. S. census data on residents of these states.[25] In addition, because 72 per cent of the questionnaires were distributed in Michigan, mainly in the vicinity of Detroit, comprehensive data provided by the Detroit Area Study[26] could also be used in the comparison.

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[24] Low, Abraham A., *Mental Health through Will-Training* (Boston: Christopher Publishing Co., 1950).

[25] U. S. Bureau of the Census, *Statistical Abstract of the United States: 1957* (Washington, D. C.: Government Printing Office, 1957), Tables 23, 45, 53, 135, 265, 585.

[26] Detroit Area Study, Survey Research Center of the Institute for Social Research, *Some Social and Economic Characteristics of the Detroit Area Population, 1952* (Ann Arbor: University of Michigan, 1953), tables II–17; V–20; VI–2, 8; VIII–9; IX–5.

A. *Socioeconomic level*

In general, the respondents were found to be of a higher socioeconomic level than other individuals in the same geographic area. This trend was maintained in respect to each of the three indices of socioeconomic level.

1. *Education:* Eighty-nine per cent of the respondents had some high school education. Data on the general population of Illinois, Michigan, and the Detroit area indicated that only 52 to 67 per cent had been in high school, and only 13 per cent had been in college.

2. *Occupation:* The respondents reported that they, or the major wage earners in their families, were employed in predominantly nonmanual occupations. Thirty-seven per cent cited employment in professional, managerial, and proprietorial occupations, and 40 per cent in industrial or service occupations. In comparison, the major type of employment in their home areas was manual, with only 16 to 20 per cent employed in professional, managerial and proprietorial occupations, and 51 to 62 per cent in service or industrial occupations.

3. *Family income:* Unfortunately, the data on family income do not permit a direct comparison because the respondents' incomes are for the year 1957, while the other information pertains to 1955. However, there is some indication that a higher percentage of respondents had family incomes of over $5,000 as compared to residents of the Detroit area or urban families in the United States. Sixty-seven per cent of the Recovery incomes were over $5,000 as compared to only 48 to 56 per cent of the Detroit area and general U. S. incomes.

B. *Religious preference*

In general, the religious composition of the respondents' group was similar to that of the Detroit area and to the available statistics on the total U. S. population.

C. *Family status*

1. *Marital status:* There appeared to be a higher proportion of married persons in the sample than in the general populations of Michigan and Illinois. Eighty-three per cent of respondents were currently married as compared with 67 to 69 per cent of residents of the two states. However, the Detroit area population included almost as high a proportion of married persons as the sample.

2. *Family size of married persons:* There appeared to be no difference in the family size of the married respondents and the married residents of the Detroit area. No comparable statistics about residents of Michigan and Illinois were available.

D. *Age*

There was a slight tendency for respondents to be younger than the population of their home communities. Fifty-five per cent of respondents were between the ages of 21 and 41 as compared to 45 to 52 per cent of the general population.

E. *Sex*

The respondents' sample was composed predominantly of women. Seventy-eight per cent were females as compared with the approximately even distribution of males and females in their home areas.

It should be kept in mind, however, that these findings are based on a 41 per cent return rate of the questionnaires. This may

suggest that the responding Recovery members constitute a selective sample of the total Recovery membership. However, this point may be minimized if the following factors are taken into account:

(1) The distribution of respondents in terms of such surface variables as age and sex corresponded to systematic observations of attenders at meetings.

(2) The responses on questionnaires returned earliest were similar to responses of those returned as much as six months later.

(3) A 41 per cent rate is not unusually low for a study of this nature.

(4) Although 1,875 questionnaires were sent to Recovery headquarters, it cannot be ascertained that all were distributed. This implies that the response rate is 41 per cent at minimum, but may be higher.

(5) The members were urged strongly by the Recovery leaders to fill in the questionnaires.

Thus, while it may not be assumed that the respondents are representative of the entire Recovery membership, they do represent that part of the membership most actively involved in the organization.

II. Membership Patterns of the Respondents

In general, the respondents indicated that they were active in a number of voluntary community organizations. Only 31 per cent of the respondents were not members of any voluntary community organizations other than Recovery. The nonmembership rate for the Detroit area population was only slightly higher at 37 per cent.[27] However, a review of studies of membership in community organizations in other locations has estimated nonmembership rates to range from 35 to 74 per cent.[28] In comparison to these findings, the respondents would seem to be relatively active in community organizations.

III. Relationship of Extent of Participation in Voluntary Community Organizations to Selected Personal Characteristics of the Respondents

The respondents were divided into three groups on the basis of the extent of their participation in other voluntary community organizations. Selected personal characteristics of the 234 respondents who reported belonging to no other such organizations were compared with those of the 347 respondents who reported having one or two additional memberships and those of the 176 respondents who reported three or more such memberships.[29] Table 1 is a summary of the results.

A. *Socioeconomic level*

In general, number of memberships in voluntary community organizations was found to be positively associated with each of the three indices of socioeconomic level. All relationships were significant at beyond the .001 level.

1. *Education:* Number of memberships was found to be positively related to number of years of formal education. Forty per cent of the respondents who belonged to three or more voluntary community organizations reported having gone to college as compared to only 19 per cent of the respondents who belonged to no such organizations.

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[27] Axelrod, M., "Urban Structure and Social Participation," *American Sociological Review*, 21(February, 1956), 13–18.

[28] Scott, J. C., *op. cit.*

[29] Questionnaires of 22 respondents who did not answer the questions concerning membership in voluntary community organizations were not used in this analysis.

TABLE I

Number of memberships in voluntary community organizations for selected personal characteristics

		Number of memberships				
	None	1–2	3 or more	Chi Square	df	P
A. Socioeconomic Level						
1. *Education*				29.87	4	.001
0–8 years	17%	8%	8%			
9–12 years	64%	60%	53%			
Some college	19%	32%	40%			
2. *Occupation*				31.69	4	.001
Professional, managers and proprietors	27%	35%	54%			
Clerical and sales	27%	22%	20%			
Industrial and service	45%	43%	27%			
3. *Family income*				21.48	4	.001
Below $5,000	41%	32%	23%			
$5,000–$8,000	41%	44%	41%			
Above $8,000	18%	24%	36%			
B. Religious Preference				35.92	4	.001
Protestant	45%	53%	60%			
Catholic	48%	41%	23%			
Jewish	7%	6%	17%			
C. Family Status						
1. *Marital status*				3.65	2	.20
Married	79%	83%	87%			
Single, widowed or divorced	21%	17%	13%			
2. *Family size of married persons*						ns
No children	16%	10%	11%			
1–2 children	54%	55%	60%			
3 or more children	30%	35%	30%			
D. Age						
21–40	63%	53%	47%	10.42	2	.01
41 and above	38%	47%	54%			
E. Sex						ns
Male	22%	23%	20%			
Female	78%	77%	80%			

2. *Occupation:* Number of memberships was found to be related to level of occupation of the respondents or of the major wage earner in the respondents' families. Fifty-four per cent of the respondents who belonged to three or more voluntary community organizations reported that the major wage earner in their family was employed in a professional, managerial or proprietorial capacity, while only 27 per cent reported employment in an industrial or service occupation. In comparison, in the group of respondents belonging to no other voluntary community organizations, only 27 per cent were employed in professional, managerial or proprietorial capacities, while 45 per cent were in industrial or service occupations.

3. *Family income:* Number of memberships was found to be positively related to annual family income. Of the respondents who belonged to three or more voluntary community organizations, 36 per cent reported family incomes of over $8,000, while only 23 per cent reported family incomes of less than $5,000. In contrast, only 18 per cent of the respondents who belonged to no organizations reported family in-

comes of over $8,000, while 41 per cent reported family incomes below $5,000.

B. *Religious preference*

Number of memberships in voluntary community organizations was found to be significantly associated with religious preferences at beyond the .001 level. There tended to be a higher proportion of Protestant and Jewish persons in the group of respondents who belonged to three or more voluntary community organizations (60 per cent and 17 per cent respectively) than in the group of respondents who belonged to no such organizations (45 per cent and 7 per cent respectively). Conversely, there was a higher percentage of Catholic persons in the group with no other memberships (48 per cent) than in the group with three or more memberships (23 per cent).

C. *Family status*

No significant relationship was found between family status and number of memberships in voluntary community organizations. In terms of marital status, a slightly higher proportion of the respondents who belonged to three or more organizations were married persons. Among the married respondents, no relationship was found between number of children and number of memberships in voluntary community organizations.

D. *Age*

Number of memberships was found to be positively related to age at the .01 level. Fifty-four per cent of the respondents who belonged to three or more voluntary community organizations were 41 years of age or older as compared to only 38 per cent of the respondents belonging to no organizations.

E. *Sex*

No relationship was found between number of memberships in voluntary community organizations and the sex of the respondents.

DISCUSSION

Certain selected personal characteristics of members of a self-help organization in the mental health field were studied in order to determine whether the same selective factors which have been associated with membership in voluntary community organizations in general were also operating in this special case.

The members were found to differ from the general population of their home communities in certain respects, the differences being those that would be expected between joiners and the general population. The members of the self-help organization tended to have a relatively high socioeconomic status. They had attained a higher level of formal education and were more frequently employed in professional, managerial and proprietorial capacities than adult residents of their home communities.

Although the data obtained on family income may not be exactly comparable, the members of the self-help organization also tended to have higher family incomes. In addition, a higher proportion of the members than of the general population were married. In these respects, the members of Recovery, Inc. were found to share the characteristics associated with membership in voluntary community organizations in general.

No differences were found between the members and the general population in the distribution of religious preferences, although it has previously been found that Protestant and Jewish persons tend to join

more frequently than Catholic persons. The fact that this particular self-help organization has received public approval from individuals in the hierarchy of the Catholic Church may explain the lack of expected difference.

In respect to sex distribution, the majority of the members of the self-help organization were women. Although men had been found to be more frequent joiners of voluntary community organizations than women, men had also been found to join fraternal type organizations more frequently. Women, on the other hand, were found to be more frequent joiners of church and religious groups and of betterment organizations. Thus it is not surprising that, although men are more prone to be joiners, they are not more frequent joiners of a self-help organization in the mental health field.

In respect to age and number of children, the differences that would be expected between joiners and the general population were not found to exist between the self-help organization members and the residents of their home communities. However, as mentioned previously, other studies had not fully agreed as to the exact nature of the relationship of age and number of children to membership in voluntary community organizations.

In general, the comparison of the self-help organization members and the residents of their home communities indicated that the members of this specialized group shared many of the personal characteristics attributed to members of voluntary community organizations. The members tended to be active in other organizations besides Recovery, Inc. Their participation rate was at least as high as, and probably higher than, participation rates revealed by other studies. Although the members of this self-help organization were either former mental patients or persons afflicted with psychiatric difficulties, they do not present the picture of social isolation and withdrawal usually associated with mental illness.

When the personal characteristics of the self-help organization members who were inactive, moderately active and very active in other voluntary community organizations were compared, most of the relationships which would be predicted on the basis of previous studies were found to be highly significant:

(A) Extent of membership was positively associated with educational level.
(B) Extent of membership was positively associated with occupational status.
(C) Extent of membership was positively associated with family income.
(D) Protestant and Jewish persons were more frequent joiners than Catholic persons.
(E) Extent of membership was positively associated with age.

In addition, married persons were found to be joiners more frequently than nonmarried individuals, although this relationship was not significant at the .05 level. No relationships were found between number of children and extent of participation, and sex and extent of participation.

To make certain that membership in Recovery, Inc. was a voluntary act on the part of the respondents rather than a form of treatment prescribed by their physicians, an analysis of the respondents' reasons for joining was made. Only 12 per cent of the respondents indicated that they had joined Recovery on the advice of a physician. The vast majority reported joining because they had heard about the organization from friends or relatives or had read about it in the lay press. This would tend to indicate that the joining of this organization was as voluntary in nature as the joining of other community associations.

The findings indicate that the same selective factors associated with the joining of voluntary community organizations in general apply to the special case of the joining of a self-help group in the mental health field. Although this study was conducted on only one self-help organization in the mental health field, there is no reason to believe that other such self-help groups would not function in respect to selectivity of membership in the same way as Recovery, Inc.

If such selectivity of membership does exist, as the results of this study show, then the utilization of self-help organizations in the field of rehabilitation may be limited to only certain segments of the population of persons with psychiatric difficulties. Such organizations may have appeal only to the type of individual who would ordinarily join voluntary community organizations.

SUMMARY

When a self-help organization was viewed as a special case of a voluntary community organization, it was found that members of the self-help organization exhibited many of the same personal characteristics attributed to the joiner in general. The members of the self-help organization were found to differ from other residents in their home communities in a number of ways which would be expected to exist between joiners and the general population.

In addition, despite the fact that the members were either former mental patients or persons who were encountering psychiatric difficulties, they were found to be relatively active in other voluntary community organizations besides the self-help group. A comparison of the self-help organization members who were inactive, moderately active and very active in other voluntary community organizations revealed the same type of relationships between extent of participation and selected personal characteristics that had been obtained in general studies of voluntary community organizations.

Book Reviews

SEX OFFENSES

In *Law and Contemporary Problems*, Vol. 25, Spring, 1960, No. 2

Durham, N. C., School of Law, Duke University, 1960, 160 pp.

This book fills a long-felt need among those who are concerned with penal reform with respect to sexual offenses. It is also of value to the ordinary citizen (especially in his role as parent) to the educator and to the therapist. It is a book which should be in the hands of everyone who helps formulate or administer the law.

The School of Law of Duke University is to be complimented for having brought together so many separate but related facts with such erudition and in such a highly readable form. In the foreword it is stated that the gestation of this symposium has been a long and rather curious one.

The proposed theme, that of sexual crimes, was broached some five years ago when the topic seemed to be a significant and timely one (the first Model Penal Code formulations concerning sex offenses had just been promulgated after much thought and discussion by the American Law Institute) and it was one that lent itself to the cross-disciplinary sort of treatment that the publication *Law and Contemporary Problems* frequently employs. It took five years, however, before it was concluded that the time was ripe—owing primarily to the interest generated by the latest American Law Institute proposals—for the full-scale integrated discussion that had been envisaged earlier.

This symposium has hopefully been designed to examine critically and comprehensively the social control of unconventional sex practices. Because the comparative study of the different approaches that have been taken to the problem has long been recognized as a most effective means of opening new perspectives and of affording valuable insights and guides to solution, attention has been given to British and Scandinavian experience in this area.

The contributors have sought to survey and analyze the crazy quilt of law governing sex offenses in this country, with an eye to delineating the course of the historical development of these laws and to assaying their essential validity from anthropological, ethical, sociological, psychiatric and biological points of view. Because legislative, judicial and popular attitudes seem to reflect a profound anxiety concerning children and adolescents (regarded as especially susceptible to sexual victimization) this facet of the subject has been intensively elaborated. The authors have marshaled their facts and formulated their views with due regard for scientific objectivity, but clearly, reform is their aim.

One chapter deals with the biological determinants of human sexual characteristics, another with the genetic-dynamic considerations that add to an understanding of the problem and contain implicit suggestions for preventive and therapeutic measures.

Three chapters by different authors deal with how people of our own and other cultures actually behave sexually. Another deals with how the law views this behavior. The marginal status of the adolescent is given a chapter to itself. The remaining three chapters, one on the ethical view and one each on the British and Scandinavian experience, deal more with what society's and the law's attitude has been, is and could be, or even ought to be—in the light of the evidence presented—as to the absurdity of the present situation. The first two sentences of the opening chapter state

the thesis of the book. These are: "A rational code of sex offense laws is long overdue in this country. Sex offense legislation presently on the books is largely unenforceable and much of this legislation does a great deal more harm than good." The writers provide ample material to prove their thesis.

The reader is left with the feeling that humanity never seems to progress evenly but rather by fits and starts, and nowhere is this more apparent than in the attitude taken to what is regarded as deviant sexual behavior. The task of separating that which is actually or potentially harmful from that which is of no legitimate concern to anyone other than the voluntary contracting adults who practice it has never been approached with the courage, objectivity and real desire for reform which is needed if anything constructive is to be done in this field. Encouraging, indeed, are statements such as the one contained in the 1949 report of the Joint Committee on Psychiatry and Law appointed by the British Medical Association and the Magistrates' Association (entitled the "Criminal Law and Sexual Offenders") to the effect that "fines should not be imposed on sexual offenders, except in cases where such offenders, after a finding of guilt, refuse to acknowledge their offense, or refuse, or are unable to co-operate in treatment," and the one in the report of the Departmental Committee on Sexual Offenses against Young Persons, 1925, to the effect that "the subject matter of the Committee's terms of reference lie on the borderline between law and morals, and there is no frontier more controversial."

This report also pointed out that, in general, "the law is not concerned with private morals or with ethical sanctions but with the outward conduct of citizens insofar as that conduct injuriously affects the rights of other citizens. It has always been thought right to bring certain forms of conduct within the scope of the criminal law on account of the injury they occasion to the public in general."

Such statements give promise of dawning insight on the part of the ever-widening group of experts who have concerned themselves with the effectiveness or lack of effectiveness of our present methods of dealing with sexual offenders.—ALASTAIR W. MACLEOD, M.D., Montreal, Quebec, Canada.

THE CENTRAL NERVOUS SYSTEM AND BEHAVIOR: SELECTED TRANSLATIONS FROM THE RUSSIAN MEDICAL LITERATURE

Collected papers for the Participants of the Third Macy Conference on the Central Nervous System and Behavior, held under the Joint Sponsorship of the Josiah Macy, Jr., Foundation and the National Science Foundation, Princeton, N. J., February 21–24, 1960.

Washington, D. C., Dept. of Health, Education and Welfare, 1960, 1,051 pp.

The familiarity of most students of animal behavior with the basic tenets of Pavlovian physiology may be dramatically contrasted with the relatively few non-Russian-speaking neurobiologists who are familiar with the trend of current research in the Soviet Union in the general area of "higher nervous activity."

In an attempt to remedy this situation and to permit a more fruitful interchange of ideas on problems of mutual interest, the Josiah Macy, Jr., Foundation and the National Science Foundation cosponsored a series of interdisciplinary conferences on the Central Nervous System and Behavior

with scientists from the Soviet Union. The volume of selected translations reviewed here was prepared by the Russian Translation Service of the National Institutes of Health as source material for participants of the Third Conference, which was devoted to the general problem of the development of behavior in animals and man.

Thus, the large number of papers concerned with various aspects of this problem reflects the specific aims of the conference program and does not constitute a random sampling of the Soviet Union's current research on the central nervous system and behavior, as might be inferred from the title of the volume.

These preliminary remarks aside, it may be helpful to note briefly the subject material contained in the 70 papers selected for translation. More than half of the reports are devoted to studies on the development of behavior in animals and human infants (somatic and visceral reflex activity, conditioned reflexes and development of speech and voluntary activity in children). Included in this series are studies on the morphogenesis of human cerebral cortex and histochemical and biochemical studies on the immature nervous system. By and large, the translations are lucid (allowing for relatively minor typographical errors), and attempts have been made, whenever possible, to include reproductions of figures, charts, and bibliography.

The contributions of Luria and his associates to the study of speech development in children are already well-known to students of Soviet psychology. The reader will find in the present collection of translations four papers, illustrated with abundant data, which include restatements of the principles outlined by Luria in his book *Problems of Higher Nervous Activity of Normal and Abnormal Children.*

Especially interesting, also, are studies dealing with the development of conditioned reflex activity in human infants. In the papers devoted to this subject, emphasis is placed on elucidating the evolutionary principles underlying behavior in order that the results of such ontogenetic analyses may serve "as a foundation for the solution of the problems of the rational training of young children" (Kasatkin).

The reader will judge for himself whether the data presented in support of this statement are as yet sufficient to warrant consideration of their applicability to such problems. However, whatever one's philosophical prejudices are on this matter, it is clear that prior to the publication of Kasatkin's studies, which attempted to establish certain laws for the formation of conditioned reflexes in the child during ontogenesis, little attention had been focused on this important problem. It is of further interest that the work of Kashkovskaya (1953) on the development of the first conditioned reactions in newborn infants under normal and in certain pathological conditions also represents the first study of its kind reported in the world literature.

The inclusion of these reports in the present volume is thus of great importance. They should be required reading for those who would tend to disregard the unusual primitive associational activity demonstrable in the newborn human infant. In addition to studies dealing with development of unconditioned and conditioned reflexes and "psychic activity" in infants, reports are included on the ontogenetic changes in reflex regulation of renal function (Nikolenko), the development of heat polypnea in pups (Hahn), and the rate of maturing of spinal reflex arcs in rabbits (Troitskaya).

The latter paper clearly demonstrates that the lack of scientific communication

between Soviet and Western neurophysiologists is not unilateral. For example, Troitskaya presents morphophysiological evidence for the functional integrity of spinal reflex arcs prior to myelinization and argues that the latter process does not determine the preparedness of nerve fibers for the accomplishment of functions. The references cited by this investigator fail to note earlier works of many Western neurophysiologists who provided clear demonstrations of this fact.

In any collections of reprints of scientific reports, irrespective of their origin or nature, one is likely to encounter some of outstanding caliber and others of doubtful significance. The present volume is no exception.

Thus, one wonders if the report by Krylov on the relationship between changes in higher nervous activity and the bromide content of the blood in monkeys during ontogenesis is likely to evoke enthusiasm among non-Soviet neurophysiologists. For while it is clear that injected bromide can cause marked changes in the degree of expression of orientation-investigatory reactions and conditioned reflex activity (as was first demonstrated by Pavlov), it is doubtful whether the notion that higher nervous activity is regulated by bromide-containing hormones with different physiological activities will have any general appeal.

This is not the case with other studies, such as those reported by Khudorozheva on the role of neurohumoral factors on the development of the functions of skeletal muscles in ontogenesis. If the claim of Khurdorozheva that the cerebellum is a source of trophic substances that can alter the membrane properties of skeletal muscles during development is substantiated in other laboratories, it would seem to this reviewer to be of considerable significance. The experimental design is certainly easily reproducible and should require little, save imagination, to confirm the results.

Lest it be understood from the foregoing that the reader is not likely to encounter reports in the present volume that evoke familiarity with the subject material, it should be noted that strictly morphogenetic and neurochemical studies are also included.

Of the latter, ontogenetic studies on the distribution of brain phosphatase and the topography and turnover of proteins in the central nervous system in relation to age are especially noteworthy. Perhaps it is because these reports are presented in a style more familiar to readers of English-language journals of neurochemistry that they are particularly appealing.

Four papers in the present volume are concerned with electrophysiological analyses of the development of conditioned reflex activity in man. The work of Voronin and Sokolov on the electrophysiological correlates of the formation of temporary associations with dampening of the orientation reflex has been viewed with considerable enthusiasm by many Western neurophysiologists.

This report amply illustrates the usefulness of electroencephalography as an analytical tool in attempting to define the neurophysiological basis of complex behavioral activities in man. What is of far greater significance, however, is the manner in which Voronin, Sokolov and their associates have incorporated experimental data on the role of subcortical reinforcing mechanisms in their provocative hypothesis on the formation of temporary associations.

Suffice it to say that these studies, taken together with those of Western workers (who are quoted extensively in the report by Voronin and Sokolov), should eventually lead to a general neurophysiological theory

of learning which is based on recognition of the activity of subcortical as well as cortical synaptic organizations in the formation of temporary connections. Other reports on related subjects in the present volume clearly indicate the concern of Soviet behavioral physiologists with attempts to redefine some Pavlovian concepts in the light of new electrophysiological data on nonspecific projection systems.

Apart from reports dealing with developmental studies of the central nervous system which, although distributed randomly throughout the volume, nevertheless provide a central theme, the reader will encounter a potpourri of recent (circa 1958) reviews and philosophical discussions dealing with tissue evolution, cybernetics, genetics, biophysics and embryology.

In each of these papers, the position of Soviet scientists is clearly enunciated at the outset and the historical evolutionary principle guiding research in these diverse areas of investigation is laboriously affirmed. The patient reader will be amply rewarded with surveys which should serve to ally (or reinforce) any preconceived notions he may have had concerning the status of Soviet research in these fields.—DOMINICK P. PURPURA, M.D., Columbia-Presbyterian Medical Center, New York, N. Y.

THE INFORMED HEART: AUTONOMY IN A MASS AGE

By Bruno Bettelheim

Glencoe, Ill., The Free Press, 1960, 309 pp.

In this very moving book Dr. Bettelheim attempts to draw lessons from the Nazi death camps for the world of today. It is his thesis that the impersonal forces of mass society pose a threat to the humanity of men and their innerpersonal integrity, similar in kind, though less in degree to that achieved by the purposively directed Nazi terrorism.

He feels that an analysis of the reasons that the vast majority of the people in the camps ceased to be men long before they were killed, and that, in spite of this, a few managed to survive not only physically, but with the inner core of their personalities intact, should provide clews for maintaining personal integrity in the face of the pressures of mass society.

A large part of the book is devoted to an account of life in the camps and to an analysis of what happened to different personalities as a result of the cruelty, degradation and humiliation. Although this is all done in a coldly objective way, this reviewer found the accounts so moving that he was able to read only a few pages at a time.

It is well that these pages of history should not be forgotten. We should always remember that the Nazis discovered the means by which large masses of men and women could be wholly robbed of their humanity. And we should also know that there were those who were able to maintain their inner strength in the face of all that the Nazis could do to them.

To read this account is a chastening experience which compels the reader to reexamine his own integrity. It is also chastening to read the account of the way Hitler little by little eroded the independence of the Germans. Each new demand seemed so small that, to most Germans, surrender on the point did not seem to matter much, but in the end the will to resist was completely broken.

The lesson seems clear that if a man's personal responsibility is to be maintained, the first encroachment upon it must be resisted. It is a mistake to wait for the serious crisis, when a stand must be taken. If the

erosion is managed in small enough increments, the serious crisis never occurs.

Dr. Bettelheim leaves the implications of his analysis—and its application to the problems of two decades later—largely to the reader, but he sums up his thought in the last two paragraphs of his preface:

"The daring heart must invade reason with its own living warmth, even if the symmetry of reason must give way to admit love and the pulsation of life.

"No longer can we be satisfied with a life where the heart has its reasons, which reason cannot know. Our hearts must know the world of reason, and reason must be guided by an informed heart. Hence the title of this book: for the rest it must speak for itself."

—TEMPLE BURLING, M.D., New York State School of Industrial and Labor Relations, Cornell University, Ithaca, N. Y.

Notes and Comments

CARE AND TREATMENT

A new program which will make psychiatric help for emotionally disturbed gang members readily available in the neighborhoods where gangs operate is being initiated by the New York City Community Mental Health Board, the New York City Youth Board and the Jewish Board of Guardians, a voluntary mental health agency. The Community Mental Health Board has allotted $94,433 for the first year's operations.

A psychiatric team will be formed to work in high delinquency areas in the city in conjunction with Youth Board street club workers. The team will consist of two psychiatrists, two psychiatric social workers, a psychologist, a social caseworker, an anthropologist and a research specialist.

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Construction on additional facilities for Milledgeville, Ga., State Hospital and for the Georgia Training School for Mental Defectives at Gracewood began last spring. Included in the Milledgeville expansion will be a 627-bed addition to the Arnall Building, a 500-bed intensive treatment and training center, a central kitchen, and a staff dormitory and staff apartment building. Immediate plans for Gracewood include the construction of a new 300-bed infirmary.

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Open house for the new, combined quarters of the Berkeley, Calif., State Mental Hygiene Clinic and the recently established Center for Training in Community Psychiatry were held last spring.

Dr. Portia Bell Hume is newly named chief of the state's program for training psychiatrists and other physicians in community psychiatry. Dr. Hume's pioneering work helped establish the Short-Doyle Act for Community Mental Health Services.

Also dedicated in California recently was the Fairview State Hospital for the Mentally Retarded at Costa Mesa. Fairview, in effect, began 13 years ago with its approval by the state legislature on the basis of need for additional beds for care of the mentally retarded. Today the hospital has 34 wards with a total bed capacity of 1,946 and with completion of additional planned buildings in 1963, the hospital will have a projected capacity of 2,600 and a staff of about 1,500.

AWARDS

Recipients of the 1960 Albert Lasker journalism awards given for outstanding reporting on medical research and public health in the newspaper, magazine and television fields included: Berton Roueche for his "Annals of Medicine: Alcohol" in *The New Yorker;* Don Seaver for his series on "North Carolina's Neglected Mentally Ill Children" published in *The Charlotte Observer;* the CBS-TV network for "Biography of a Cancer" program and KCRA-TV, Sacramento, for "Face of Despair," a program about the care of the mentally ill.

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Sheldon Glueck, Roscoe Pound professor of Law at Harvard, is the tenth winner of the American Psychiatric Association's $1,000 Isaac Ray Award given annually to a psychiatrist or member of the bar for "furthering understanding between the two professions." As recipient, Dr. Glueck will deliver a series of lectures on psychiatry and the law during the academic year 1961–62 at Tulane University, New Orleans.

GRANTS

Establishment at the University of Minnesota of a clinical drug evaluation center for the intensive study of compounds affecting abnormal human behavior has been assured by a $427,804 four-year grant from the National Institute of Mental Health.

Principal investigators for the project, in which psychotic patients in Minnesota mental institutions will participate, are Dr. Burtrum C. Schiele, professor of psychiatry, and Dr. Gordon T. Heistad, associate professor of clinical psychology.

APPOINTMENTS AND ELECTIONS

Dr. Benjamin Pasamanick, professor of psychiatry at the Ohio State University and director of research at the Columbus Psychiatric Institute and Hospital, has been named the Percival Bailey Lecturer for 1961. He will speak on "Some Misconceptions Concerning Racial Differences in the Prevalence of Mental Disease" at the Illinois State Psychiatric Institute in November.

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Dr. James B. Craig has been named assistant superintendent of Milledgeville, Ga. State Hospital. Dr. Craig was professor of psychiatry at Ohio State University College of Medicine and clinical director of the Columbus Psychiatric Institute.

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The Society for the Scientific Study of Sex has announced the results of its first election of officers. Dr. Albert Ellis, is president; Dr. Christopher Tietze is president-elect; Dr. Hugo G. Beigel is secretary and Robert V. Sherwin is treasurer. The fourth annual meeting of the Society will be held November 14, 1961, at the Barbizon-Plaza Hotel in New York City.

Dr. James H. Sterner, medical director of Eastman Kodak Company, was recently elected president of the National Health Council. Dr. Sterner is the first industrial physician to be elected to this post.

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Peter G. Meek has been named executive director of the National Health Council succeeding Philip E. Ryan who became executive director of the National Association for Mental Health May 1. Mr. Meek has been director of the New York Office and Northeast regional representative of the National Society for Crippled Children and Adults since 1956.

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Dr. H. Elson Hooper has been appointed chief of psychology research for the Veterans Administration. Dr. Hooper was formerly chief of the central research laboratory at the Augusta, Ga., VA hospital for the VA's co-operative psychological research.

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Dr. Charles E. Niles has been named deputy commissioner for administration of the New York State Department of Mental Hygiene.

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Dr. Oscar K. Diamond has been appointed director of Manhattan State Hospital, Ward's Island, N. Y.

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Dr. Fritz Redl, distinguished professor of behavioral sciences at Wayne State University, Detroit, was elected president of the American Orthopsychiatric Association at the recent annual meeting of the organization. Dr. Edward D. Greenwood, coordinator of the training program in child

psychiatry for the Menninger School of Psychiatry in Topeka, Kan., was named president-elect.

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At the meeting of the Board of Trustees of the Academy of Religion and Mental Health in June Erwin S. Wolfson, chairman of the Diesel Construction Co. of New York City, was elected president of the board to succeed Dr. Harvey J. Tompkins. Mr. Wolfson is the first layman to be elected president of the Academy. Dr. Warren Weaver, for many years vice president of the Rockefeller Foundation and now vice president of the Alfred P. Sloan Foundation, was elected vice president of the Academy.

MEETINGS, INSTITUTES, SEMINARS

The thirteenth Mental Hospital Institute of the American Psychiatric Association will convene at the Sheraton-Fontenelle Hotel in Omaha, Neb., October 16–19. The main theme will be "New Perspectives on Mental Patient Care: A Consideration of *Action for Mental Health,* the final report of the Joint Commission on Mental Illness and Health."

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The theme of the mid-winter meeting of The Academy of Psychoanalysis, to be held at the Hotel Commodore in New York City on December 9 and 10 is "Psychoanalytic Education." Officers of the Academy for 1961–62 include Dr. Roy R. Grinker, president; Dr. Sandor Rado, president-elect; Dr. Joseph H. Merin, secretary, and Dr. John L. Schimel, treasurer.

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The eleventh annual meeting of the National Association for Mental Health will be held at the Deauville Hotel in Miami November 15–18. Featured will be a review and evaluation of the final report of the Joint Commission on Mental Illness and Health.

STUDIES, REPORTS, STATISTICS

In June of 1959 the Indiana Division of Mental Health requested Delton C. Beier, Arnold Binder and Coy D. Robbins of Indiana University to conduct a survey to estimate the number of emotionally disturbed children in Indiana, to determine the adequacy of the treatment or care they were receiving and the needs of the state for extension and improvement of current services and facilities.

The results of this survey, recently published by the Division, suggest that the Division as well as the Legislative Study Committee on Emotionally Disturbed Children were conservative in their estimates of the immediate as well as the long-term needs of emotionally disturbed children in Indiana.

The report recommends that the state begin a broader public school program designed for emotionally disturbed children, that a preschool mental health screening program be set up on a research and trial basis, that increased facilities for outpatient care be developed, that there be more special placements outside the home, that the number of foster homes and group homes for emotionally disturbed children be increased, that there be constructed an equal number of residential units and closed and essentially custodial units for such children, that there be developed residential diagnostic and early treatment centers for juvenile delinquents and predelinquents, that more funds for research be made available, that funds be appropriated to provide scholarships to train and edu-

cate individuals in the various mental health disciplines.

• • •

Some overweight people should receive psychiatric treatment before attempting to diet, cautions Professor Charlotte M. Young, medical nutritionist on the staff of Cornell University's Graduate School of Nutrition.

Professor Young pointed out that "before becoming concerned with details of a diet, consideration should be given to whether or not the overweight patient should be subjected to a reducing regimen. Not every obese patient is a candidate for weight reduction by dietary means."

In a recent article in the *American Journal of Clinical Nutrition* she cited clinical studies that show there is a high recurrence of obesity after dieting and weight reduction, and that emotional symptoms and even mental breakdowns have been reported during the period of weight loss."

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The resident population in New York State's mental hospitals decreased by 1,240 during the past year, Dr. Paul H. Hoch, Commissioner of Mental Hygiene, revealed in a report of department statistics for the fiscal year ending March 31, 1961.

This marks the sixth consecutive year that the patient population in the state's 18 mental hospitals has shown a drop. Since the peak patient population of 93,559 on June 30, 1955, the number of resident patients has decreased by 6,189.

PUBLICATIONS

Volunteer Services in Mental Hospitals, a report of last year's Institute for Mental Hospital Directors of Volunteers, was published recently by the National Association for Mental Health. The new publication covers the course content of the Institute held in Topeka in February, 1960, under the auspices of the NAMH, the Menninger Foundation and the Topeka State Hospital with the support of the National Institute of Mental Health and the Nathan Hofheimer Foundation.

IN MEMORIAM

A memorial foundation has been established in memory of Albert Deutsch, journalist and champion of the mentally ill.[1] Mr. Deutsch, who was fifty-five years of age, died in his sleep of a heart attack June 18 in Horsham, England, where he had been attending a meeting of the World Federation of Mental Health.

The Foundation, to be known as the Albert Deutsch Memorial Foundation, will set up an annual journalists' award and will publish a memorial volume of Mr. Deutsch's writings and a biography of the late writer.

Individuals have been invited to submit anecdotal material, letters and manuscripts for these volumes. Interested persons have also been invited to send gifts to the Foundation and to act as volunteers in their communities to assist in the building of the Foundation. Gifts and other communications should be addressed to the Foundation at Room 1130, Dupont Circle Building, Washington 6, D. C.

Mr. Deutsch was known throughout the world for his editorial championship on behalf of the mentally ill. At the time of his death he was making an extensive survey of the status of psychiatric research in the United States.

His first book, *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times,* was the first of its kind to bring the shameful con-

[1] A tribute to Mr. Deutsch will appear in the January issue of *Mental Hygiene.*

ditions and neglect of the mentally ill to the attention of the American public.

His other books were: *The Shame of the States,* in 1948, a criticism of state hospitals for the mentally ill; *Our Rejected Children,* in 1950; and *The Trouble with Cops,* in 1955. He was editor of *Sex Habits of American Men,* in 1948, and co-author, with David M. Schneider, of a history of public welfare in New York State, in 1941.

Mr. Deutsch's articles appeared in the *New York Times Magazine, Collier's,* the *Woman's Home Companion, The Saturday Evening Post* and *The Reader's Digest.*

In 1949 he received an Albert Lasker award for his writing on mental health and a George Polk Memorial Award from Long Island University for reporting. In 1945 and 1946 the New York Newspaper Guild gave its Heywood Broun citations to him for reporting. In 1953 he received the Adolf Meyer Memorial Award in Mental Health. He was an honorary fellow of the American Psychiatric Association.

Mr. Deutsch was born and educated in New York City. His first job in the field of psychology was as a research associate for the state Department of Social Welfare from 1936 to 1940. From 1941 until 1950 he was a columnist for several New York newspapers and after 1950 devoted all of his time to free-lance writing.

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In a recently-published tribute to the memory of Dr. Carl G. Jung, the Academy of Religion and Mental Health cited the world-renowned physician for his "keen interest in and contributions to" the founding of the Academy. The tribute states that "some of his theories were in sharp disagreement with those of Freud but each of these intellectual giants has made our world richer because of the contributions they made toward it."

Dr. Robert A. Matthews, professor and head of the Department of Psychiatry at Jefferson Medical College in Philadelphia, was killed June 23 in a head-on collision near Williamstown, N. J. In 1956 Dr. Matthews was appointed deputy secretary of welfare and commissioner of mental health for the Commonwealth of Pennsylvania. In this position he accomplished a great deal toward the establishment of progressive programs in state mental hospitals.

He also gave much emphasis to the care of emotionally disturbed and mentally retarded children and repeatedly encouraged the establishment of psychiatric wards in general hospitals and in outpatient clinics throughout the state.

ARTICLES SCHEDULED FOR PUBLICATION IN COMING ISSUES OF MENTAL HYGIENE

"Young Indians: Some Problems and Issues of Mental Hygiene" by Elizabeth E. Hoyt.

"Open-ward Management of Disturbed Mental Patients of Both Sexes" by Magno J. Ortega.

"How to Act Toward Emotionally Disturbed Neighbors, Friends and Relatives" by Mathew Ross.

"Trends in Soviet Psychiatry" by Alex H. Kaplan.

"Some Pre-World War II Antecedents of Community Mental Health Theory and Practice" by Ascanio M. Rossi.

"Psychiatric Aspects of Police-Community Relations" by Chester M. Pierce.

"A Look at Dentistry and Psychological Concepts" by Lucille Hollander Blum.

"The Role of the Psychiatric Aide: A Report on the Norristown Seminar" by Alfred E. Goldman and M. Powell Lawton.

"Role Reversal in Geriatrics" by Arthur L. Rautman.

"MMPI Changes Following a Course in Mental Hygiene" by Frank Kodman, Jr. and Gordon Sedlacek.

"The Inadequate Chronic Alcoholic Personality" by Edward Podolsky.

"Are Monthly Meetings of Chapters of the Mental Health Association Necessary?" by Loyd W. Rowland.

"Sociodrama and Group Discussion with Institutionalized Delinquent Adolescents" by Wilson A. Head.

"Patient Participation at a Series of Rehabilitation Service Meetings" by William N. Deane.

"Beyond the Open Door" by Frank Winston.

"The Mature Person" by G. T. Barrett-Lennard.

"Some Factors in Identifying and Defining Mental Illness" by David Mechanic.

"A New Dimension for Volunteers" by Donald T. Lee.

"The Dream Comes of Age" by Kilton Stewart.

"The Dog As a 'Co-Therapist' " by Boris M. Levinson.

"Metaphysical Concerns and Mental Health" by James A. Knight.

"The Personality Need Structure of Psychiatric Attendants" by Alexander Tolor.

"The Assessment of School Phobia" by Donald A. Leton.

"The Functions of Day-Care for Disturbed Adolescents" by Harold W. Pfautz.

"A Look at a Moscow Mental Hospital" by Sheldon G. Weeks.

"Views of a Mental Hospital" by Robert Sommer and Robert Dewar.

"Preparing Public Health Nurses for Mental Health Problems" by Esther Schulz and Dorothy Brown.

"Educative Psychotherapy with Student Nurse Classes: An Investigation of Socially-Shared Conflicts and Value Distortions" by Herman P. Gladstone.

"Common Record Forms: A Study of Psychiatric Agency Co-operation" by Richard M. Silberstein and Wallace Mendell.

"Community Attitudes Toward Family Care" by William T. Bowen and Gloria J. Fischer.

"The Role of Vocational Rehabilitation in Today's State Mental Hospital" by Harvey E. Wolfe.

"Contributions of a Nurse in an Adult Psychiatric Clinic: An Exploratory Project" by Jules V. Coleman and Rhetaugh Dumas.

"Cultural Considerations in the Teaching of American Psychiatry to the Chinese" by Col. Richard R. Cameron and Lt. Col. Fernando G. Torgerson.

"The Personal Emergency Advisory Service" by Allen A. Bartholomew and Margaret F. Kelley.

"Social Life" by Simon Olshansky.

"The Effects of Manifest Anxiety on the Academic Achievement of College Students" by Charles D. Spielberger.

"Returning Mental Patients to the Community: An Analysis of Placement Failures" by Leslie Navran.

"Problems in Administration and the Establishment of Community Mental Health Services" by Herbert Dorken.

"Personality Changes Among Members of Alcoholics Anonymous" by Felix Cohen.

"Primary Essentials for Organizing and Administering a Successful Institutional A. A. Program" by Arthur F. Clagett.

"Changing Trends in Psychoanalytically-Oriented Psychotherapy" by Lawrence L. LeShan.

"Suicide: A Cultural and Semantic View" by William Urban.

"A Systematic Approach to Mental Health Assessment and Counseling" by Leonard T. Maholick.

"The Outlook for Mental Health Education" by Harry Milt.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a co-ordinated citizens' organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.

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